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ABSTRACT

The objective of this Legislative Symposium was to assess the rural health care system of the State of New York, and in light of the current influences on that system, to design a framework for rural health care over the next two decades. The tasks of the participants were to reconfigure the rural health care system and make proposals on system design, system development, and needs assessment. Over 125 people participated in the symposium and were divided into five workgroups: System Framework; Access; Reimbursement; Personnel; and Coordination. These workgroups outlined the central issues in each of these subjects with five common concerns: regulatory flexibility; reimbursement and financing mechanisms; coordination; networking and community strategic planning; and the unique character of rural needs, strengths, and conditions. Sections of the report are (1) "Executive Summary"; (2) "Synopses of Guest Faculty Presentations"; (3) "Creating the Proper Environment for the Development of Rural Health Systems"; (4) "The Rural Community"; (5) "Reconfiguring the Traditional Health Care Model"; and (6) "Workgroup Reports and Public Comment." Appendices include information about programs for rural health delivery; classification of New York counties on a metropolitan-rural continuum; a list of symposium participants; and a list of agencies, associations, and councils that directly affect rural health policy and delivery systems in New York State. This report is of potential interest to educators and policymakers concerned with the quality of life in rural areas and the antecedents of student performance in schools. It may also be of interest to extension educators and those involved in interagency collaboration. (ALL)

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The Design of a Rural Health Services System For the Next Two Decades

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August, 1988

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A Rural Resources
Special Focus Report

The Design of a Rural Health Services System For the Next Two Decades

Legislative Symposium Proceedings
April 29 - May 1, 1987
Bassett Hall Conference Center
Mary Imogene Bassett Hospital
Cooperstown, New York

New York State Legislative Commission on Rural Resources
August 1988

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The Legislative Commission on Rural Resources wishes to thank all of the conference attendees and those who kindly consented to the use of their photos in this report.

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To the Readers of this Special Focus Report:

Senator Cook delivers the opening address at the Second Symposium on Rural Health Care, held at The Mary Imogene Bassett Hospital in Cooperstown, N.Y.

As Chairman of the Legislative Commission on Rural Resources, I am pleased to present the final report of the second symposium on rural health care. This report highlights the concerns and recommendations of those involved in the provision of rural health care services across the state.

Over 125 people participated in the two-day symposium, which was held April 29 to May 1, 1987, at the Bassett Hospital Conference Center in Cooperstown, New York. The participants represented a broad spectrum of organizations, institutions, providers and others involved in the provision, planning and regulation of health care in rural areas. In addition, attendees were joined by an excellent faculty of rural health care experts from across the country.

After distributing a preliminary report on the symposium, the Commission held a series of hearings between September 1987 and January 1988 to solicit public comment on the recommendations put forth in the report. Testimony was received from over eighty individuals and organizations.

The Commission members and staff have a strong commitment to the development of a rural health care system that is built on the unique character and values of the rural community, and addresses its need for quality, accessible health care. In conjunction with the many people who have offered their time and expertise to further this goal, we have been able to develop legislative proposals and other initiatives to make our commitment a reality.

On behalf of the members of the Commission, I would like to express our appreciation to all those who participated in the symposium and the public hearings. With continued representation of the rural community in the development of state policy, we can look forward to even greater successes in the future.

Senator Charles D. Cook
Chairman
Legislative Commission on Rural Resources

August, 1988

Special Thanks

State legislative leaders who took part in the Second Statewide Rural Health Symposium were Senators Charles D. Cook, Tarky Lombardi, Jr., John M. McHugh and James L. Seward, and Assemblymen William L. Parment, John G.A. O'Neil, and Anthony J. Casale. Congressman Sherwood Boehlert updated participants on rural health initiatives in Washington. Senator Alfonse D'Amato expressed his interest and support of rural New Yorkers' health needs via his Washington representative, Grace Morgan. Governor Cuomo was represented throughout the conference by Joseph Gerace, Director of the State Office of Rural Affairs. In sparing so much time from busy schedules, these officials recognized the great concern rural residents have about diminished access to health care.

That concern was also demonstrated by the numbers of participants who came from every region of the state and a broad spectrum of public and private organizations and facilities. Their names and affiliations are cited in Appendix C.

Special thanks go to Mary Imogene Bassett Hospital and its Director, Dr. William F. Streck, who hosted the conference and gave necessary support every step of the way.

The conference planning committee was composed of John V. Andrus, David L. Boucher, Ronald C. Brach, Jo-Ann Constantino, Leonard M. Cutler, David W. Davis, Paul Fitzpatrick, Seth Gordon, Mickey Hall, Darrell Jeffers, Warren Marcus, Robert Reid, Ronald Rouse, Robert L. Telford, Carol Frank Dye, Christine Pushkarsh, Irwin Rockoff, and Bruce Stanley. Their energy and expertise was essential in putting the conference together and making it work. Thanks, too, is due to the state legislators, state agencies and organizations these staff members represented, for sparing their services to help plan and manage the conference.

Ten guest faculty were on hand to deliver remarks and assist the various workgroups. These experts came from around the country and made outstanding contributions to the conference's success. They were: Bruce Amundson, Jeffrey C. Bauer, Marsha Kilgore, John A. Krout, Ira Moscovice, Richard Nelson, Steve Rosenberg, James L. Scott, Cecil G. Sheps, and Timothy K. Size. Abstracts of their remarks are included in this report.

A ***Rural Health Resource Guide*** was prepared in advance of the conference by Commission staff members Julie Austin, Peter Fredericks, Joseph Nash, Mary Shands, and Thomas Stalter. This served as an information resource for all participants. The staff are recognized for their special contributions to the conference's success. Our editor, Diane Hill, put together and typeset the final report of the proceedings.

Finally, we wish to acknowledge and thank Mary Traynor and Julie Austin for writing this report and Keith Kinally for his expert review of an early draft — thus creating an accurate account of the 1987-88 symposium proceedings and public hearings that dealt with the future design of rural health delivery systems in New York State.

Ronald C. Brach
Executive Director
Legislative Commission on Rural Resources

Executive Summary

"The results of studies demonstrated that the quality of care in rural swing-bed programs either equalled or surpassed that found in comparable nursing homes."

Marc Mendelsohn
Community General Hospital
of Sullivan County
December 1987 (Schoharie, NY)

The health care delivery system across the state is under tremendous pressure to continually assess the quality and efficiency of care provided, and to curb the amount of public and private resources consumed in the delivery of services. The Commission on Rural Resources recognizes the unique stress these demands place on health care delivery in rural areas, where efficiencies available to the urban areas of the state are not always present.

In 1985, the Commission responded to these growing concerns by sponsoring its first rural health care symposium. Participants from across the state came together to highlight the problems and needs in the rural health care community and to propose some general solutions to address those needs. The majority of issues raised were related to three general factors:

- The lack of a coherent state rural health care policy and blueprint for the development of health care services within rural areas;
- The many institutional and regulatory impediments with which rural health care providers must continually struggle; and
- The special costs of delivering health care in a rural setting.

While that first symposium provided guidance to the Commission in developing its legislative package for 1986, much more remained to be accomplished. Fundamental changes in the health care system were occurring at a rapid pace, including the closure or threatened closure of many rural hospitals. Thus, in response to requests from the health care industry, the Commission held a second symposium in 1987, in order to obtain the assistance of experts in the field in developing more specific strategies to address the many issues raised at the first symposium. The objective of the symposium was to assess the rural health system, and, in light of current influences on that system, to design a framework for rural health care over the next two decades.

A steering committee was formed to develop the outline and structure of the symposium and was instrumental in laying out the issues and tasks to be confronted by the participants, articulating the charge to the symposium to reconfigure the rural health care system, and defining system design and development issues and needs assessment demands. The committee also issued an outline for a **Rural Health Resource Guide** which was compiled by the Commission staff.

Participants in the symposium — over 125 people — represented rural health care consumers and providers, local government, community agencies and organizations, state legislators, and policymakers from the State Departments of Health, Social Services, and Education and the Office of Rural Affairs. Various statewide organizations involved in the development of health policy were also in attendance. The steering committee suggested the inclusion of rural health care experts from around the country who would share their ideas and experience with the audience, as well as guide the workshop discussions and provide participants with objective feedback on the proceedings. The guest faculty brought new insight to the discussions, including important information regarding programs in other states.

"In essence, we're required to deliver the same quality with the same type of personnel, yet we're reimbursed less, and that is a known fact."

Scott Parisella
Salamanca District Hospital
November 1987 (Corning, NY)

In order to effectively address the broad spectrum of issues in rural health care, participants were divided into five workgroups: **System Framework; Access; Reimbursement; Personnel; and Coordination.** The workgroups outlined the central issues in each of these subjects and brought forth recommendations for consideration by the full symposium.

As was expected, there were several concerns common to all categories and they will be highlighted throughout this report. They are: regulatory flexibility; reimbursement and financing mechanisms; coordination; networking and community strategic planning; and the unique character of rural needs, strengths, and conditions. Some of the specific recommendations related to these issues follow.

Regulatory Flexibility:

There was a general consensus that a rigid, strict regulatory oversight of the health care field, characteristic of New York State health policy, precludes the ability of small rural communities to develop innovative ideas to more effectively address local health care needs. In addition, assumptions underlying the development of regulations are applicable only to metropolitan-based care, are often considered too strict or even counterproductive, and often create undue hardships. Some of the specific recommendations include:

- Placing a moratorium on the involuntary closure of rural hospitals until assurance can be made that proper methods of health care delivery exist in those communities;
- Allowing rural hospitals to use a portion of their acute care beds for the types of care needed in the community, from intermediate to long term care. This discretionary power is based on the development of 'swing beds';
- A waiver of the Certificate of Need (CON) process for rural hospitals, to allow a ten percent change in certified bed capacity on a temporary basis, in order to respond to seasonal fluctuations in demand for services;
- Flexibility in staffing requirements to allow rural health care facilities to continue providing needed services, taking into consideration problems in the recruitment and retention of certain health care professionals, as well as the lower patient volumes associated with the delivery of certain procedures in less densely populated areas; and
- Examining regulations under which rural providers must operate, identifying regulations inappropriate for rural providers, state regulations that are in excess of federal requirements, and regulations which should be relaxed or eliminated. This examination should extend beyond health care regulation to include related areas such as education, transportation and environmental conservation.

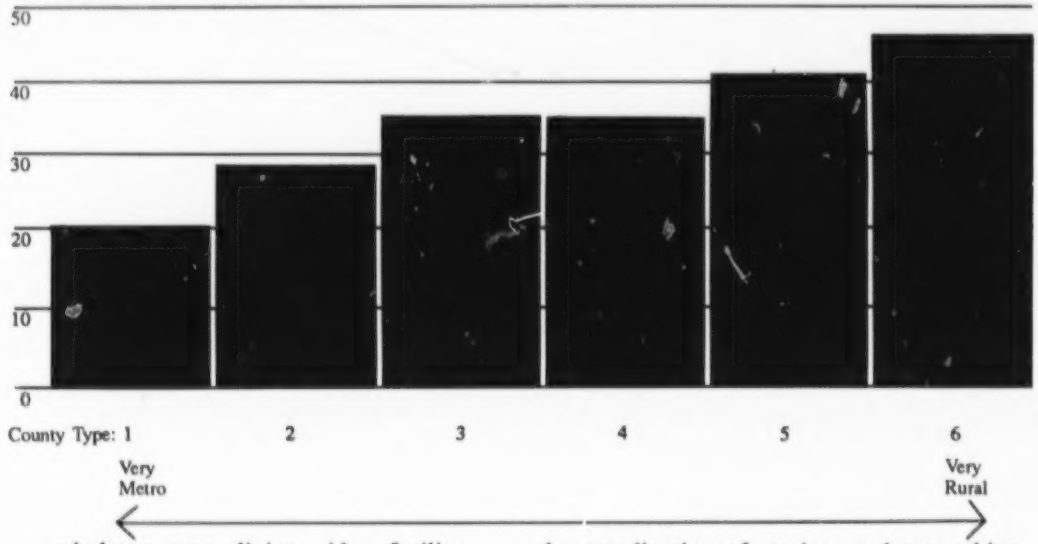
Reimbursement and Financing Mechanisms:

Rural health care providers generally receive lower financial reimbursements for services provided, primarily because the cost of labor has traditionally been lower in rural areas. However, this policy does not take into consideration that rural providers must compete for personnel with providers in metropolitan areas, especially for high level professional staff. In fact, some rural providers must pay a premium in order to attract certain health professionals to rural areas. In addition, capital financing for equipment, renovations and expansion is difficult to obtain due to the complexity of application procedures and high fees. Major recommendations in the area of reimbursement and financing include:

- Price blending should be limited in reimbursement methodologies for rural hospitals, residential health care facilities (RHCFs), home care agencies and

Accidental Death Rate - 1986 (No. of Deaths per 100,000 pop.)

(See Appendix B for explanation of County Types)



Accidental death rates are significantly higher in rural areas than in metropolitan areas, due in great part to much higher motor vehicle accident rates, as well as farming and other high-risk employment.

ambulatory care clinics. Also, facility-specific wage equalization factors should reflect actual experience rather than regional rates;

- Methods of third party reimbursement for mid-level practitioners — such as nurse practitioners, physician's assistants, and nurse anesthetists — should be developed;
- Reimbursement for services such as primary care, preventive care, ambulatory care and home care should be expanded (including adequate coverage of transportation costs for home care workers);
- A capital financing pool should be developed at the state level oriented toward rural health care providers, with reduced costs and streamlined application procedures.

"I am concerned mostly about representation, about not getting an opportunity to really voice our concerns adequately to the Health Department, to the HSAs, or to the Legislature."

Timothy Reardon
Adirondack Regional Hospital
September 1987
(Saranac Lake, NY)

Coordination, Networking and Community Strategic Planning:

One of the strongest themes running through all five of the workgroups was that there is a need for a health care planning process which is locally determined and based on the coordination of services and networking among health care providers. Coordination and networking are necessary at the state level as well as the local level. Health care planning should be considered a local responsibility and should reflect the different sets of problems, resources, and priorities found in each community. The recommendations include:

- Increased coordination between local health providers, regional Health Systems Agencies (HSAs), the state Department of Health and other state agencies;
- A state-level ombudsman for rural health and health-related care in the Office of Rural Affairs. Two specific recommendations were: creating an office of rural health under the auspices of the Office of Rural Affairs; and creating a council for rural health and human services, as an advisory council to the Director of the Office of Rural Affairs;
- Funding and assistance for rural communities to establish Health Service Development Bodies, which would act at the local level to coordinate health care and human services, to disseminate information, and to develop local case management systems;

- Encourage the development of consortia of rural health care providers to increase operating efficiency by sharing information, resources, services and personnel;
- Develop and enhance support systems (including transportation, housing, and vocational counseling) in rural communities; and
- Develop and expand programs to ensure the continued existence of emergency medical system receiving facilities.

"We wholeheartedly agree that networking is the essential glue which fastens together any service continuum. After all, rural people have been helping each other heal and stay healthy since long before there were Commissions, symposiums and 20-year plans."

Lynn Olcott
Planned Parenthood,
Orleans County
October 1987 (Albion, NY)

Addressing Unique Rural Needs, Strengths, and Conditions:

Several suggestions were also made during the symposium which deal directly with the uniqueness of health care services delivery in rural areas. These include:

- Developing a mechanism for providing state technical assistance to local health care providers in areas such as coordination, grant-writing and rate appeal preparation;
- Promoting volunteerism, particularly by providing state tax credits to volunteers and encouraging local governments to do the same;
- Establishing a state-level recruitment and retention program to assist rural providers in meeting staffing requirements;
- Providing monetary incentives, such as grants, scholarships and loan forgiveness programs, to encourage students from rural areas to enter health training programs and locate their practices in rural communities;
- Establishing Regional Health Education Centers as focal points for information and continuing education in rural areas;
- Establishing and expanding information and awareness programs to ensure that the rural public, and particularly school children, are knowledgeable about career opportunities in the health care field;
- Providing financial incentives to telephone companies serving rural areas to develop 911 emergency communications systems; and
- Promoting and intensifying training programs for first aid and CPR in the public school system.

Summary of Public Testimony and Comments:

Between September 1987 and January 1988, the Legislative Commission on Rural Resources held five regional public hearings across the state to solicit comment on the preliminary *Report of the Second Legislative Symposium: The Design of a Rural Health Care System for the Next Two Decades*. The report outlined the discussions which took place during the symposium, held April 29 to May 1, 1987 at the Bassett Hospital Conference Center in Cooperstown. The hearings were held in Saranac Lake, Albion, Corning, Schoharie, and Albany.

This summary of public testimony and comments received during the Commission's public hearings is divided into sections reflecting the five workgroups of the symposium. The sections are titled: System Framework; Access; Reimbursement; Personnel; and Coordination. Over 85 people testified at the public hearings including representatives of local government, rural health care providers, consumers, and community and state agencies and organizations.

System Framework

The recommendations of the Workshop on System Framework were well received throughout the state. In general, the components of the rural health care system, representing a continuum of health care services stretching from prenatal and infant care to services for the elderly of the community, were reiterated in each of the five public hearings. Particular concern was expressed regarding the need for additional

innovative mechanisms for addressing the health and social services requirements of our elderly population, especially services which can be provided in the community, such as home care and support services.

The overall design of the system, as outlined by symposium participants, was echoed throughout the public hearings. The health care delivery system should be designed in the local community with technical assistance and regulatory flexibility on the state level. The emphasis would be on local planning and decisionmaking. There was marginal support for continuing the current system of health planning. In general, the speakers expressed concern that the planning bodies not become pseudo-regulatory bodies reflecting the needs and dictates of the Department of Health but rather serve the needs of the local community and health care providers. Others spoke to the current inability of the planning system to address the needs of the local community because of the large geographic regions served, and the mixture of rural communities and urban areas within those regions.

The comments reflect a continued perception on the part of the local community of the hospital as the "hub" of the local health care delivery system. Many speakers endorsed the Commission's request for a moratorium on the involuntary closure of rural hospitals until such time as a well-defined health care delivery system is developed which could ensure sufficient coverage for each rural community. Premature action on the part of the state Department of Health was viewed as a threatening development. At the same time, there was a call for immediate action on the part of the community to examine the role of the local hospital and develop new and innovative service ideas to meet the health care demands of the community in the most efficient and effective manner. Examples of efforts of rural hospitals to address the need for diversification included the development of community health education programs, new drug and alcohol abuse programs, and cardiac rehabilitation programs.

Access

A common issue raised in almost every hearing was the need for an adequate emergency response system, particularly in light of the movement to change the roles of community hospitals which will lead to increased travel in emergency situations. Volunteer squads remain the principal providers of emergency services and face steep obstacles in their efforts to recruit, train and retain their volunteers.

Access to the full spectrum of health care services was also of concern to the speakers. Several of those testifying pointed out that rural residents may be subjected to a two-tiered health care system by virtue of where they live. It was also noted that access is a problem in all human services, going beyond health care to support services such as nutrition counseling, social services, adult day care and homemaker assistance.

Reimbursement

The status of the state's post-1987 hospital inpatient reimbursement system for non-Medicare patients was still undecided at the time the hearings were held. However, a great deal of concern was expressed regarding the use of 1980 cost data trended forward under the proposed legislation. Several speakers pointed out that the data used to determine the trend factor do not reflect the reality of rural hospital experience. The costs for the recruitment and retention of health care professionals, for example, are not adequately represented in the trend factor. Few, however, were able to give projections of the impact of the new system.

Another reimbursement issue raised by a number of participants at the hearings was the need for third party reimbursement for nurse practitioners, nurse anesthetists, and other mid-level practitioners. Increased use of these health care professionals would enhance rural health care services and also increase cost-efficiency.

There were also complaints about the Medicare program and the lack of an adequate differential for rural facilities.

Medicare assumes that expenditures such as labor costs are lower in rural areas, when in fact, the lack of economies of scale and the inability to compete with urban counterparts have been demonstrated. Individuals testifying asked that the state become more active in lobbying for changes in the federal program which would treat rural facilities more equitably.

Personnel

Several recommendations were made regarding the current regulatory system established to train and certify emergency services personnel. Those recommendations are essentially reflective of the discussions at the symposium, including: additional funding for the training of personnel; training sites in the local community, held during hours which do not conflict with normal working hours; a review of the requirements for an emergency medical technician (EMT) to be present on every call; and, a state commitment to emergency medical services which is consistent and sufficient to provide a high quality service.

"The report for the first time presents a realistic evaluation of the health care status of rural New York State and shows sensitivity to the economic need to retain health care providers, particularly hospitals, in rural locales."

Anthony McKenna
Inter-Community Memorial Hospital
October 1987 (Albion, NY)

In addition, funding for the recruitment and retention of the full range of health care professionals was requested by speakers from all over the state. The inability of rural hospitals to compete with urban facilities for health professionals has strained the budgets of many of these facilities and left them at a loss in recruiting new staff and keeping the wages of current staff competitive. The problem extends far beyond institutions, however, presenting itself in public health services, home health care, and other community-based services.

Coordination

The public comments concerning coordination revolved around the innovative programs being initiated at various sites across the state. The major problem expressed by the speakers is the lack of technical assistance and financial support for these projects. Most felt that coordination would naturally occur in local areas given the necessary support, and is gradually happening now throughout the state.

Another problem noted by hearing participants is the undue delay in obtaining a Certificate of Need (CON) through the Department of Health and local HSAs. Very often, a CON is required for health care providers in order to diversify services. Finally, as was noted during the symposium, the need for coordination involves coordination among state agencies; among local providers, practitioners and agencies; and between the public and private sectors.

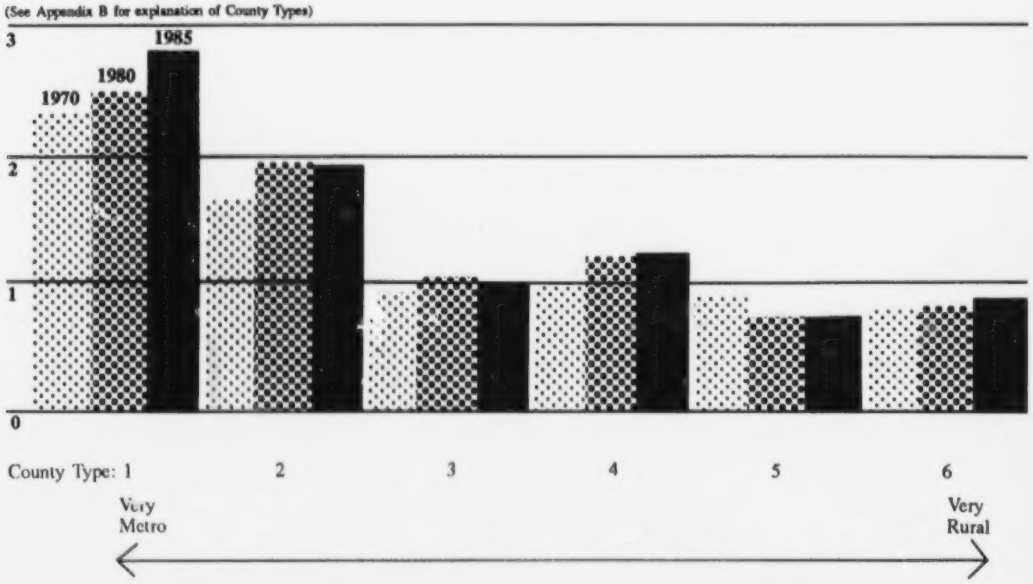
Actions to Date:

Over the past few years the Commission on Rural Resources has continued to develop policy recommendations in the form of state legislative proposals. Several of these initiatives have been enacted into law, including the following:

- Rural Health Care Networking Program (1986), which established a grant program to assist rural health care providers in pursuing joint ventures and cooperative agreements.
- Rural Hospital Swing-Bed Demonstration Program, to assist rural hospitals in planning and developing swing-bed demonstration projects.
- Physician Recruitment, Retention, and Clinical Training in Rural Areas, which funds enhancement of a model program at the Department of Family Medicine of the State University of New York at Buffalo School of Medicine.
- Rural Health Care Research and Training Program, established in 1988 to enable graduate students in health care administration to undertake rural health research projects and/or to obtain practical experience in a rural health care facility.
- Rural Health Care Provider Diversification Program, which supports projects by providers that will expand, diversify, or enhance the services they

Physician Distributions, 1970, 1980, 1985 (per 1000 pop.)

(See Appendix B for explanation of County Types)



The availability of physicians throughout the state has traditionally been skewed toward metropolitan areas, with severe shortages in some rural counties.

offer. There is a heavy emphasis on expanding the availability of both primary and long term care in rural communities. Since its inception in 1987, funding for the program has been maintained at $1 million per year.

- Rural Health Care Development Program, which received funding of $1 million in 1988-89, is similar to the Provider Diversification Program in advancing the diversification of provider services in primary and long term care, as well as geriatric care, rehabilitation, and emergency medical services. However, the projects covered do not involve the conversion or merger of existing acute care facilities.

In addition to legislation, the Commission maintains an ongoing dialogue with the Department of Health and other state agencies regulating rural health care, as well as representing New York State interests on a national level. The Commission members consider such cooperation critical to focusing attention on the needs and concerns of rural New Yorkers. (Additional information on the work of the Commission and other agencies and organizations is provided in Appendix A.)

Synopses of Guest Faculty Presentations

Guest Faculty members gather for a photo with Senator Cook. From left to right: Senator Cook, James Scott, Bruce Amundson, Marsha Kilgore, John Krout, Jeffrey Bauer.

The Commission on Rural Resources was fortunate to have assembled an outstanding guest faculty for the symposium. These ten individuals, intimately involved with rural health care throughout the nation, are highly regarded in their respective fields. Not only did they deliver excellent presentations — each member also served as a resource expert on a workgroup.

Following are synopses of the guest faculty presentations, which broadly outline the subject matter treated by each speaker. They illustrate a diverse experience and outlook regarding proper rural health care policy and delivery — a diversity reflected in the wider assemblage of participants. The views expressed by these presenters do not necessarily always reflect the Commission's position, but they have provided an excellent basis for problem solving by rural health policymakers, providers, and citizens throughout the U.S.

James Scott

James Scott is president of the American Healthcare Institute in Washington, D.C. In the past, he has worked for the Health Care Financing Administration in Washington and Baltimore; the Department of Health and Human Services; the Kansas Hospital Association; the American Hospital Supply Corporation; and as administrator of four small, rural hospitals.

Mr. Scott presented a review of the American Healthcare Institute's legislative proposals to address the needs of rural hospitals. These include:

- Refining the area wage index to distinguish among different skill levels of hospital employees;

Other members of the Guest Faculty with the Senator: From left to right: Ira Moscovice, Senator Cook, Richard Nelson, Timothy Size, Cecil Sheps, and Steven Rosenburg.

- Providing a better accounting of outlier expenditures and permitting unexpended funds to be carried forward for use in the next fiscal year;

- Allowing rural hospitals with more than fifty beds to participate in the swing-bed program and base the payment rate on the Medicare SNF rate rather than the current Medicaid rate. (Note: the bed-size limit was raised to ninety-nine beds as a part of the Budget Reconciliation Act passed in the Spring of 1988.);

- Modifying the definitions of Rural Referral Centers and Sole Community Providers to include a special payment and adjustment to help finance the costs of maintaining core staff and services, and to allow Sole Community Provider status to hospitals that undergo consolidations resulting in a reduction of inpatient acute care beds; and

- Requiring a specific percentage of on-site PRO reviews in rural hospitals, and insuring that providers are aware of specific criteria and have had the opportunity to take actions before sanctions or denials are issued.

Mr. Scott noted that the American Healthcare Institute recognized that the financial problems of small, rural hospitals would not be eliminated by the enactment of these provisions. These particular recommendations had been adopted because they were both sound policy and politically achievable.

Marsha Kilgore

Marsha Kilgore has been the Manager of Oregon's Office of Rural Health since its creation in 1979. She is also on the Board of Directors of the National Rural Health Association, and beginning in May 1987, started a three-year term as the Association's President.

Ms. Kilgore described Oregon's Office of Rural Health — why and how it was created, and what it does. That Office was created by state statute in 1979 and has been funded by state general funds since its inception. Primary responsibilities include coordination of statewide resources impacting rural health; acting as an information clearinghouse; providing technical and financial assistance; developing legislation to help improve rural health care in the state; and helping in the recruitment, placement and retention of health care professionals in medically underserved areas of the state. (Additional responsibilities were added by the state legislature in July 1988, including special attention and assistance to rural hospitals throughout the state.)

The Office is advised by a 16-member Rural Health Coordinating Council whose membership includes representatives from the public and the health care industry (both public and private).

The top five rural health problems in Oregon were cited and include: (1) lack of primary care providers (physicians as well as nurse practitioners and physician's assistants); (2) inadequate financial resources due to a small population base and an economic decline in rural areas;
(3) malpractice/liability crisis;
(4) uncompensated care, particularly with the underinsured, uninsured, and the reimbursement differential by Medicare between rural and urban areas; and (5) lack of adequate health care management skills and access to those skills.

Some of the solutions cited to address these problems were: planning from both a statewide and local perspective; technical and financial assistance; coordination at the state and local level; communication and information sharing; a system that goes beyond basic primary care to include public health, home health, hospitals, nursing homes, emergency care, mental health, etc. Ms. Kilgore stressed the importance of a statewide commitment to the above and the importance of the three "C's" — coordination, communication, and cooperation. She also emphasized the importance of community commitment as well as the importance and necessity for state and federal assistance to rural areas.

Ms. Kilgore urged the need for working jointly, planning and evaluating, exploring different options, and communicating and sharing information.

John Krout

Dr. John Krout is an Associate Professor of Sociology at the State University of New York at Fredonia, and author of the book, *The Aged in Rural America*. Dr. Krout has written articles published in the *International Journal of Aging and Human Development*, the *Journal of Gerontological Social Work*, *The Gerontologist*, *Research on Aging*, and the *Journal of Applied Gerontology*. Some of the courses he teaches at Fredonia are: Aging, Introduction to Gerontology, Aging in Rural America, Aging Policies and Programs, and Social Demography.

Dr. Krout began his presentation with some background on rural New York's demographics. He stated that because there is much diversity in rural New York, making generalizations is difficult. He also raised the question of what exactly is "rural," and pointed out that this is not an academic issue, but is one which must be addressed. "Rural" has cultural, economic,

demographic, organizational and social dimensions which must all be considered when examining and responding to health issues. Finally, he emphasized that the health issues of rural New York cannot be addressed in isolation, but should be viewed in the context of the health issues of the state as a whole. Dr. Krout then directed the participants to think about the goals of the symposium. Was the objective truly to design a rural health care delivery system to meet the anticipated needs of rural New York over the next two decades, or rather to make recommendations that would provide the best physical and mental health for rural people that current and future resources can support. In other words, Dr. Krout emphasized, focusing on the system may divert attention from important aspects of individual health.

The disadvantaged status of rural residents, demonstrated by their poorer health status, was an issue Dr. Krout considered fundamental. Rather than take these health status discrepancies for granted, he said, we should examine them and learn from them. Thus, we should determine the areas in which rural health is poorest (e.g., chronic, acute) and what factors account for this (i.e., nutritional, attitudinal, environmental, behavioral, socioeconomic, and/or professional health care system). Finally, Dr. Krout stated that policy initiatives should be directed to these areas.

Legislative and regulatory policy activity, as Dr. Krout pointed out, traditionally focused on unmet health care needs and issues related to health service delivery. An emphasis must be placed on re-orienting the public policy process and focusing on the following:

prevention and education rather than treatment; consumer participation rather than bureaucratic control; long term care rather than acute care; home care rather than institutional care; proactive rather than reactive; major changes rather than incremental approaches; content rather than process; and decentralization rather than centralization.

Finally, Dr. Krout stressed the need 'to look past the present,' and direct efforts toward the future. He emphasized demographic trends, as well as planning for acute and long term institutional and home care needs, with consideration of alternative methods of delivering health and related support services, such as swing beds and caregiver supports. Dr. Krout stated that we need to break from the present ("Do we need more of the same? Is it just a question of dollars?"), in order to make the most of limited resources and preserve local autonomy.

Jeffrey Bauer

Dr. Jeffrey Bauer, from Hillrose, Colorado, holds a Ph.D. in Economics and is a nationwide consultant in Health Administration. Author of three books and thirty articles, Dr. Bauer is involved in two specific areas: rural hospital consolidation projects and rural EMS system development. He also teaches at the University of Colorado in Denver, and is on the long-range planning committee for a twenty-nine bed hospital. From 1973 to 1984, he was administrator of the University of Colorado Health Services Center and a professor at the same institution.

Dr. Bauer asked the audience to challenge some "old truths" about rural health care:

- **You can't have rural health care without rural hospitals.** This is not always the case, as more and more frequently we find health services provided in other settings, such as clinics, the workplace, and the home. Thus, we need to concentrate on the *function* of making health care available and accessible, rather than on its traditional *form*.

- **You can't have rural emergency care without rural hospitals.** The emphasis is shifting from emergency *rooms* to emergency *care*. Appropriate and prompt

on-scene intervention is more important than the final destination, and resources should be used to strengthen the rural emergency system. One strategy is to supplement the limited volunteer system with full-time professional EMTs.

- **You can't have rural doctors without rural hospitals.** New increasing pressures are limiting the traditional doctor-hospital relationship, and rural physicians face growing difficulties in providing hospital-based care, while finding it more financially efficient to practice primary care in a private setting.

- **A doctor is a doctor is a doctor.** Simply *having* a doctor is not necessarily adequate for a rural community, because not all physicians practice "good medicine." Also, expectations in rural areas are different than metropolitan expectations, so patients' perceptions must be taken into account. New emphases on progressive responses and on quality measurements (e.g., JCAH) must have a rural dimension.

Dr. Bauer said, "the new truth is that rural health care can be better provided in different ways. The old concerns — hospitals and doctors — limit our vision. Our new concern should be with function, then with form designed to match . . . We are not stuck with what exists. New thinking is more likely to produce improvements, if not solutions." Some suggested new approaches include infirmary/short-stay observation facilities, the three-doctor primary care practice, professional/volunteer EMS systems, and regionalized secondary and tertiary care. Dr. Bauer concluded by saying, "expect things to come out a bit different."

Bruce Amundson

Dr. Bruce Amundson is Assistant Professor in the University of Washington's Department of Family Medicine. He directs the Rural Hospital Project and is also Associate Director of the Office of Rural Health for Washington, Idaho, Montana and Alaska.

In his presentation, Dr. Amundson began by exploring the differences between external and internal forces impacting a community's rural health care system. External forces, he explained, include health care and demographic trends, reimbursement issues, and regulatory forces. These are all forces over which rural communities have relatively little control. They should be distinguished from internal community issues, which are often less well defined and more poorly addressed by rural communities. Examples include effectiveness of rural community leadership, hospital trustee skills and effectiveness, shortages of physicians, nurses and other providers, lack of strategic planning, intracommunity conflict and patient outmigration for health services.

Dr. Amundson went on to describe the W.K. Kellogg-funded Rural Hospital Project (RHP), a four-year demonstration project designed to stabilize and improve the provision of health services in a sample of isolated, small rural communities in the states of Washington, Alaska, Montana and Idaho (WAMI). The underlying tenet of the RHP is that substantial change and improvement in rural health services delivery can only be accomplished by mobilizing broad public interest and community support.

The RHP seeks to improve rural health care systems by engaging community and health care leaders in a self-reinforcing process of beneficial change. By concentrating initially on the status of the rural hospital, the project captured the immediate attention of rural communities for whom the hospital is a concrete representation of the community's investment in health care.

The project has five phases: community selection; analysis of the community health system; community health services planning; implementation; and evaluation and dissemination.

Following community selection, an extensive analysis was performed of the delivery system in each community. The project observed that a crucial issue, comprehensive analysis and problem identification, is often performed inadequately and incompletely by rural communities. The comprehensive community analysis included a market survey for the community service area, a key informant needs assessment, a study of the financial and management systems of the hospital and other institutions, and a review of demographic and economic trends in the community.

The data from the analysis outlined above became the key ingredient for the next phase of the RHP, community health services planning. An important finding from this part of the project was as follows: communities with no history of even hospital strategic planning found it necessary to first initiate or complete an institutional strategic plan. This was followed by community-wide planning for issues of importance in the entire health services system. Strategic planning goals from the community planning process were broad and will not be discussed in detail. They are reflected in the array of strategic initiatives and programs which have been implemented as a result of this planning.

All participating communities have implemented a broad range of strategic changes. Five of the six hospitals have improved their financial status; utilization has increased substantially in three of the six hospitals; three community PPOs have been initiated and another is being considered; two community health care foundations have been established; four of six communities have added primary care physicians; and nurse recruitment strategies have borne results in two sites.

A model governance system for small rural hospitals was developed through the project and implemented in all sites. The model requires clearly defined mission, goals, and objectives for each hospital. All boards have implemented annual retreats, developed an annual work plan, streamlined their decision-making process including board meetings, and examined and often revamped their board structures. Explicit attention to the role of the board chairperson has resulted in changes in most communities and clearly enhanced board leadership and effectiveness.

Several communities with conflicting relationships within the health system have implemented team-building strategies. In each community where poor relationships threatened the effectiveness of the overall work plan, marked improvement in the quality of teamwork has been achieved.

By working with a sample of rural communities, the RHP has produced a community health services development model which is based on community development principles. Several innovations, according to Dr. Amundson, appear to be important in explaining the impact on participating communities.

Generating an unusually comprehensive, systematic data base with a thorough indexing of each community's health services problems has been very valuable.

Dr. Amundson concluded his comments with the Rural Hospital Project's main finding to date: "it is reasonable to assume that the likelihood of individual rural communities salvaging and strengthening essential health services in the future is more dependent on their capacity to react, lead, and change than on their affecting changes in the external environment." Furthermore, the RHP has shown that its approach, described as the community health services development model, can successfully strengthen a community's health services system.

Richard Nelson

Richard Nelson, M.D. is Associate Professor of Pediatrics and Director of the Child Health Specialty Clinics at the University of Iowa. Dr. Nelson has worked in many capacities as a pediatrician, including Director of the Minnesota Department of Health Services for Children with Handicaps; Director of the Gillette Children's Hospital Developmental Disabilities Program in Minneapolis; and instructor of pediatrics at Northwestern, the University of Minnesota, and the University of Iowa. He has served on numerous committees and boards; published papers, books and abstracts; and has been involved with a number of exhibits, films, tapes and special presentations dealing with a wide variety of health care issues. Finally, Dr. Nelson has served as a consultant or participant in the work of such groups as the U.S. Department of Health; the Michigan Department of Public Health; and New York City's Albert Einstein College of Medicine, Department of Pediatrics.

Dr. Nelson's presentation topic was the regional development of Child Health Specialty Clinics (CHSC) in Iowa — a state with no dominant metropolitan area, an agricultural economy, and where the majority of the population resides over fifty miles from a tertiary care resource. Specifically, Dr. Nelson recounted the development of the CHSCs as one way a statewide health service can be organized. He traced the clinics from the beginning (a number of mobile clinics) to their present organization (a series of permanent regional clinics and local services centers). The clinics were organized through interagency efforts at both the state and local levels, and are located in the major population center within each region. The clinics' offices are generally located within the regional hospital, and situated so that all families are within fifty miles of a clinic's services and programs.

Dr. Nelson described elements he considers necessary to the success of such programs, including participation from the areas of public health, medicine, family, social services, and education; and inclusion of such services as Integrated Evaluation and Planning Clinics, and High Risk Infant Follow-Up Programs.

While Iowa's efforts were mandated by the state legislature, Dr. Nelson discussed important issues involved in organizing voluntary regional efforts. Among these issues were: identifying needs, structure and roles of the community council and its members; essential services and how to provide them; and expected outcomes. The past experiences of voluntary systems reveal a great deal of variety in performance, he stressed, with spectacular successes as well as failures, and inconsistencies in the level of enthusiasm expressed by various participants.

Cecil Sheps

Dr. Cecil Sheps is the Taylor Grandy Distinguished Professor of Social Medicine and Professor of Epidemiology, Emeritus, at the University of North Carolina. For over forty years, Dr. Sheps has been involved in teaching, research, and health care administration. Dr. Sheps has held positions at Harvard Medical School, Beth Israel Hospitals of Boston and New York, the University of Pittsburgh, and the Mount Sinai School of Medicine in New York City. He has published over one hundred and thirty-five articles and has written and/or edited nine books. His research and writing have been largely devoted to such topics as: evaluation of health care programs; problems in the organization and utilization of medical care (particularly ambulatory services); community health planning; and problems in the education of health professionals. Dr. Sheps is also a senior member of the Institute of Medicine of the National Academy of Sciences, a member of the Executive Board of the American Public Health Association, and serves on the editorial boards of *Social Work in Health Care*, the *Journal of Health*

Politics, Policy and Law, and the *Journal of Public Health Policy*.

Dr. Sheps began his presentation by describing his involvement in the establishment of an Office of Rural Health Services in the North Carolina state government. He mentioned that North Carolina's program has been functioning for over fourteen years, and is generally recognized as the most effective and comprehensive program of its type in the United States. The program has functioned in a variety of ways which have addressed the development of community medical care programs in rural communities without services, assisting with the planning and construction of facilities including financial assistance, and the recruitment of medical personnel. In the last ten years, this office has recruited 659 physicians to practice in rural areas of the state. It also provides a continuous program of technical assistance to physicians and community health centers in carrying out their programs with the maximum of effectiveness, efficiency and satisfaction to the public and the professionals involved.

After this brief introduction to his work, Dr. Sheps asserted that New York State would benefit from duplicating some of these endeavors. He pointed out that "the mistake that is often made in addressing [rural health care issues] is that people tend to look for piecemeal and instant, simple solutions instead of tackling the whole problem in terms of the greatly changing scene in health services and the basic values and needs of rural people." He then talked about the changes in health care in the U.S. since World War II — particularly the changes in, and the needs of, small and rural hospitals. Dr. Sheps conveyed the belief that hospital services for rural people must be considered on a regional basis, instead of the old 'mind set' that every community needs a hospital. He stated, "I would suggest that what we need to do in rural areas is to no longer think of the small rural hospital as being devoted solely to acute hospital care but that it should rather be thought of as the center of health services in the community which would have the responsibility for developing and organizing services of various kinds, some which require a physical location and others which require simply a base from which services are provided to the community."

Dr. Sheps concluded his remarks by commending New York State on its work in improving rural health care, and urged that the impetus be continued and efforts be made to encourage community participation. He stated, "clearly . . . a first class start has been made, the groundwork has been laid and the time for community action has now come."

Ira Moscovice

Dr. Ira Moscovice is Professor and Associate Director at the University of Minnesota School of Public Health's Division of Health Services Research and Policy. He has written extensively on the use of health services research to improve health policy decisionmaking in state government and rural health care delivery systems. Dr. Moscovice is currently conducting a national evaluation of the Robert Wood Johnson Foundation's Hospital-Based Rural Health Program.

Dr. Moscovice's presentation focused on the future of rural hospitals in the rural health care system. He began his remarks by discussing the factors precipitating rural America's current state of transition and those causing the current stress on the health care system nationwide. Some of the forces affecting the health care system include increasing expenditures, an oversupply of personnel in some fields, restrictions on reimbursement, increases in uncompensated care, technological growth, and a general restructuring of the industry.

Rural hospitals, Dr. Moscovice contends, are the hub of the rural health care system, and are as diverse as the populations they serve. He noted that one-half of the nation's

community hospitals and one-fourth of community hospital beds are located in rural areas.

Dr. Moscovice discussed various factors affecting the performance of rural hospitals. Among them are socioeconomic trends such as the increasing number of elderly people and the changing nature of the rural economy, as well as health system factors such as personnel, technology, access to capital, and reimbursement under the Prospective Payment System (PPS).

He described factors which will play a crucial role in the future viability of rural hospitals. Among those he mentioned were the societal trend toward decentralization, issues relating to the locus of control of the rural hospital, the impact of alternative delivery systems, and the role played by the health care generalist. Important issues currently facing rural hospitals include nursing shortages, the impact of PPS, and the trend toward hospital closures.

Dr. Moscovice concluded by discussing the impact of some options for rural hospitals, such as maintaining the status quo, diversification of services, and linkages with multi-hospital systems (including cooperatives and coalitions).

Timothy Size

Tim Size holds a B.S.E. in Biomedical Engineering and an M.B.A. in Health Care Administration, and has been Executive Director of the Rural Wisconsin Hospital Cooperative since 1980. He was administrator of the Hospital Metodista in La Paz, Bolivia from 1971 to 1973, and Assistant Superintendent at the University of Wisconsin Hospital and Clinics from 1974 through 1979.

The Rural Wisconsin Hospital Cooperative (RWHC) is an organization of rural hospitals dedicated to the development and operation of multi-hospital shared services as well as political advocacy for rural health care and communities. In addition, the Cooperative has developed and "spun off" several important rural initiatives, including an HMO and a mobile CAT Scanning Service.

Mr. Size began his remarks with some objections to points raised by earlier speakers. He disagreed with a speaker who discussed the problems in rural health care that were not being addressed. He offered the idea that if reviewers and state planners were rural-based looking at urban systems, rural might become the "flawless" model and the problems of the urban system "standard."

He questioned another speaker who had challenged a number of rural health "certain truths." While agreeing with some of the speaker's comments, Mr. Size cautioned that the unsubstantiated debunking of widely held beliefs creates in fact a whole new set of beliefs that might need debunking. He indicated that when working in rural areas, there is a need to focus on developing an understanding of historic community functions and beliefs while not confusing this with a requirement to maintain an unsupported adherence to past forms.

Mr. Size's prepared remarks addressed the role of the hospital and inter-community networking. He indicated that while there was not time to do so, he preferred to talk about both the attitudes necessary for networking and specific mechanisms. As he distributed a paper that describes RWHC history and mechanics, his comments focused on the attitudes and philosophy of networking.

Mr. Size commented on several of his own beliefs that have developed after eight years of rural hospital networking. For example, he pointed out that hospitals are not necessarily bricks and beds, but a community's statement of need for local health care. They are, or can be, he felt, an appropriate focal point of local health care (with or without beds). Mr. Size stated that he personally distrusts <u>both</u> central planning

and local inertia to change, since rural hospitals are not small big hospitals. In general, he emphasized that the main issue is how to best serve the local community.

Mr. Size shared his belief that American health care is inherently pluralistic and can be influenced but not totally planned. "Like a gardener, we have substantial influence, but as is said in Spanish, vegetables and flowers grow themselves; we do not grow them, we help, we plan, but they must do the actual growing."

He then asked: what are the implications of these beliefs, and what needs to be done?

Cooperate in order to compete

- Recognize inter/intra-regional competition and its economic stakes. Health planners talk about access and availability; local people talk about jobs, local economy and tax base — health dollars have a lot to do with that as well.

- Understanding cooperation among smaller economic units can be an effective means of balancing the power of large competitive units.

- Cooperation is more difficult than competition, but necessary.

Define Communities of Common Interest

- To subvert professional turf battles.

- To leave sports rivalries to high school.

- To fight like a family (with vigor, but without 'going to bed mad.')

Implications of Medicare

Mr. Size continued by sharing his deep concern about the negative impact of current Medicare policy on the future of rural hospitals and health care. While recognizing the positive changes underway in the program, he said that rural interests must keep up the demand and pressure for more radical reform. He indicated that rural communities can't afford to have people believe that several technical adjustments are enough to address the needs.

He challenged the audience with the question: "I'm from out-of-town so perhaps someone can explain to me why the Federal government says rural hospitals in New York should be paid less because you are less costly while someone in the State of New York wants to shut you down because you are too costly."

If government can't help, he said, at least they should do no harm. They have an obligation, if the public's interest is to be served, to create a fair market or 'even playing field' in an increasingly competitive environment.

He concluded with the following: "but, how well we meet our communities' expectations related to the quality and cost of health care is a responsibility clearly on us. Individual rural hospitals can no longer do it on their own; the question is, can we develop viable alternatives to take over or closure. I hope the answer is yes — strong rural networks are clearly possible but only we can make them realities."

Steven Rosenberg

Steven Rosenberg is President of Rosenberg Associates, a California-based consulting firm which specializes in providing technical assistance to community-based health care providers. In recent years, the firm's emphasis has been on rural health care systems that integrate community development with service provision. Rosenberg Associates also writes monographs, books and other materials on health care. Mr. Rosenberg has a Masters Degree in Public Health from the University of California at Berkeley.

Mr. Rosenberg presented three case studies from the files of Rosenberg Associates of rural hospitals in need of assistance: a twenty-six bed facility that was losing

$350,000 a year; a county-owned forty-bed facility with a daily census of three that was also losing money; and an eighty-nine bed facility that could not meet its debt payments. Mr. Rosenberg's consulting firm recommended that one hospital concentrate on changing the "product mix" — that is, it was recommended that the hospital change from an acute care facility to a facility consisting of acute care beds, skilled nursing beds, and a clinic. It was also suggested that the surgery unit be closed. Recommendations for a second hospital included changing the "product line" (that is, shifting from acute care services to skilled nursing and substance abuse services).

Mr. Rosenberg gave a "moral to the story" ending for each case study. Some of the morals:

- the inflexibility of regulations designed to protect public health many times threatens life in rural communities;
- an inability of facilities to stop internal bickering can threaten the community and the facility; and
- legislators often enact well-meaning laws that sometimes worsen the problems they were attempting to address.

Two overall themes emerged from Mr. Rosenberg's comments. First, the survival of many small rural facilities depends in great part on their flexibility and their ability to diversify the services they offer. Second, strategies to meet local needs and to maintain financial viability vary across facility types and geographic and political climates. Thus, efforts proven successful in one situation may not be appropriate, and may even be detrimental, in other circumstances.

Creating the Proper Environment for the Development of Future Rural Health Systems

"Success in the restructuring of rural health care systems depends on recognition by state and local policy-making bodies that such a restructuring is needed, and will require coordination of efforts. We agree that barriers to restructuring caused by a lack of resources or by regulatory impediments must be reduced by appropriate state and local policy coordination."

David Axelrod, M.D.
Commissioner, NYS Health Department
January 1988 (Albany, NY)

A Distinct Philosophy of Rural Health Care: The Foundation

In order to develop alternative rural health care systems, there must be a foundation on which to build. This foundation is a distinct philosophy of rural health care which includes recognition of the individuality of each community and its specific situation. This section outlines the components and activities essential to the creation of this foundation, as considered by participants at the symposium and public hearings.

Critical Elements of Future Rural Health Care Delivery Systems:

The restructuring of rural health care delivery systems is contingent on key elements. These include:

- Proper federal and state policy and programs;
- State, regional and community networks;
- Financing mechanisms — including Medicare, Medicaid, managed care, private insurance, employer-sponsored coverage, voucher systems and individual medical accounts;
- Coordination — including case management entities;
- Information — such as information and referral sources, health education programs, health resource centers, and health assessment programs;
- Service linkages and transportation — including public transportation, provider services, community programs, and volunteer services; and
- Direct care services (institutional, community, or home-based).

System Performance Criteria:

Performance criteria like those listed below should guide the development of rural health care systems for consumers, providers, and communities.

- Quality of Care
- Access to Full Continuum of Services
- Local Control and Autonomy
- Enhanced Health Status
- Responsiveness
- Personal Choice of Health and Lifestyle
- Maximum Resource Utilization
- Integration and Continuity of Services
- Cooperation and Coordination

Issues for Future System Design and Development:

Needs:
The process of designing and developing rural health care systems should begin with an analysis of consumer, provider, and community needs. However, current public policy has stressed urban-oriented reimbursement and regulation as the driving force. This has been particularly damaging

Median family income in rural counties is historically much lower than in metropolitan counties.

Median Family Income (in dollars)

County Type	1950	1960	1970	1980
Metro: 1	3,665	6,569	10,901	20,344
2	3,506	6,519	10,908	21,405
Rural: 3	3,240	5,779	9,993	19,513
4	2,965	5,525	9,049	17,428
5	2,798	5,432	9,622	18,917
6	2,612	4,955	8,516	16,007

(See Appendix B for Explanation of County Types)

"We also need to have an evaluation, and that's where I think the Department of Health can be helpful, of what these services are; ...there are means by which the state [health] department with its expertise can give us an evaluation, and for a coordinating council, that certainly is essential and is certainly very important."

Edwin L. Crawford
NYS Association of Counties
December 1987 (Schoharie, NY)

to rural health care systems. Specific needs discussed at the symposium were:

- Assessment of the health and lifestyle needs of rural residents and current efforts to address any imbalances.
- Assessment of the demographic, socio-economic and other trends at work and the imbalances occurring in addressing those trends.
- Assessment of the unique conditions and strengths of the rural comunity and how they serve as a foundation for the rural health care delivery system.
- Assessment of the current economic/ regulatory impact on rural providers.
- Assessment of the real economics of rural life as contrasted to metropolitan-based systems.

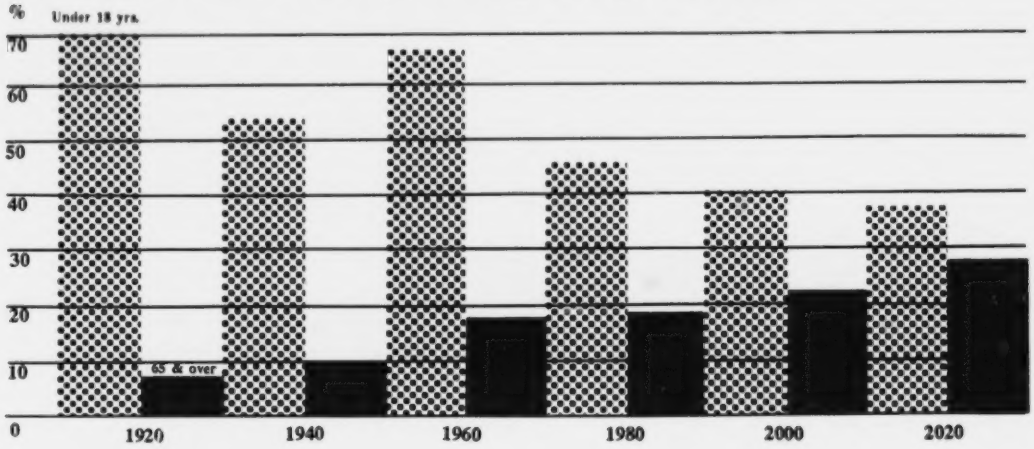
System Design:
After cataloging health needs, symposium participants identified health and health-related services that would meet those needs. They considered the following system design issues:

- When planning for the next two decades, what essential elements and types of services should be included in an ideally integrated rural health and human services delivery system?
- What properties should be emphasized in the design of each major component and type of service? What implications do these have for existing service components?
- What changes must be made?

System Development:
Participants also addressed the task of devising a proper foundation and strategies for the implementation and maintenance of future rural health systems. The following represent key system development issues considered:

- What incentives would enhance recruitment and retention of personnel?
- What incentives would encourage existing providers to participate in coordinated state or regional delivery systems?

U.S. Population Trends of Dependent Age Groups, 1920-2020



Source: Census Bureau, 1983.

In 1920, the U.S. population aged 65 and over composed only a small proportion of all dependent persons, while nearly 70% of the population was under 18. Projecting current trends, by 2020 the proportion of seniors will be about 28%, and those under 18 about 38%, of the population. We can anticipate a commensurate increase in demand for specific types of elder health care services — e.g. hospice, respite, day care and home health care. Rural areas, with proportionately larger numbers of seniors and fewer resources than metropolitan areas, will find these needs especially hard to meet.

- What incentives and approaches would promote consolidation or reconfiguration of facilities or providers where appropriate?

- What would promote greater utilization of the New York State Rural Health Care Networking Program, including involvement of private practitioners and rural health primary care centers?

- What research and development, planning and information-sharing strategies would promote improvement in the state's rural health care system?

These are but a few of the major issues involved in the design and implementation of new rural health care systems. Increased participation of rural voices in such rural health policy development was a strong request of symposium participants.

The Rural Community

To properly design health care delivery systems in rural areas, it is important to recognize that the rural community is unique and cannot be directly compared with an urban or suburban center.

"Insurance is less likely to be offered by the smaller employers found in rural areas. People privately insured, individually or through small groups, tend to have fewer benefits than large group policies provide. Medicaid is a program that tends to favor the urban poor ... It is difficult for families with two parents in the home to qualify, and rural poverty tends to more frequently take this configuration."

Marthe Gold, M.D.
O'Connor Hospital
January 1988 (Albany, N.Y.)

Health Status and Industry Issues

While certain aspects of health care delivery are universal, several factors are particularly significant to rural health care delivery. Among these are: a high rate of heart disease, alcoholism, and teenage pregnancy; a shortage of primary care, intervention and prevention services; a high proportion of elderly individuals demanding a broad range of both medical and support services; relatively undeveloped health support services, with fewer health care options; higher transportation costs and a lack of public transportation services; and relatively low financial and economic status.

The rural health care industry also faces unique problems: competition with urban centers for qualified health care professionals, a sparse population precluding the development of economies of scale; difficulty in accessing capital financing; a trend toward hospital closure; lack of measures to address the large medically indigent population; and reimbursement methodologies which do not recognize the unique costs associated with delivering health care services in a rural area. (The ***Rural Health Resource Guide***, published by the Commission, provides specific data on many health status and industry concerns.)

Strengths

Rural New York has historically offered a high quality of life for its residents. A tradition of strong values and belief systems, and integrity and compassion toward family and strangers alike are hallmarks of rural life. In addition, rural people feel responsible for the welfare of others and are dedicated to the welfare of the community at large; thus, there is a high level of volunteerism in health care and human services.

Rural health care providers have demonstrated the same values in their work. There is a greater focus on the patient as an individual, including recognition of his family life and social situation. The delivery of services is more localized, and therefore, more conducive to personalized care. This also facilitates better communication between health care professionals, and enhances the continuity of care.

Community Needs

A comprehensive, integrated health care system is important for rural development and the economic well-being of the community. The rural hospital is often the single largest employer in the community, often serving as the core entity in the health care system, with its staff and officers serving as the key players in the identification of health care needs and the planning of services to meet those needs. Health care providers and other organizations in the community are significant sources of information regarding health care education, promotion, and illness prevention.

Cherry Valley farmer Bob Scramlin helps Bassett Hospital's Farm Safety and Rural Health staff demonstrate the operation and potential hazards of farm machinery to local rescue teams.

"Rural residents have to overcome the obstacles of distance, lack of support services, access to public transportation where indeed public transportation exists, and the limited number of health care providers available to them. Large percentages of the elderly reside in rural areas and of this group of persons — over 85 — is the fastest growing age cohort in the state."

Sr. Mary Paschal-Hill
Mercy Rehabilitation Center
January 1988 (Albany, NY)

Implications for Rural Health Care Delivery

Frequently, a specialized approach to rural health care delivery is required. It cannot be assumed that metropolitan models will be responsive to rural needs and conditions.

Service alternatives designed for a densely-populated metropolitan center are often not applicable to rural health care delivery and thus may need to be redesigned in order to assure that rural systems operate at their peak. For example, home care was originally conceived as a cost-effective means of serving residents in the central city. However, while having many medical and psycho-social benefits, the metropolitan home care model is seldom a less costly alternative to institutional care in rural areas.

Hospitals, Nursing Homes, Diagnostic and Treatment Centers, and Indigent Care Clinics in Upstate New York Counties

Counties	Hospitals	Residential Health Care Facilities*	Clinics	Indigent Care Clinics**
Albany	4	13	9	1
Allegany	2	4	2	0
Broome	3	10	3	1
Cattaraugus	4	6	2	0
Cayuga	1	4	4	0
Chautauqua	5	10	1	0
Chemung	2	6	2	0
Chenango	1	4	1	0
Clinton	1	7	2	0
Columbia	1	5	1	0
Cortland	1	2	2	2
Delaware	5	4	2	0
Dutchess	4	10	5	0
Erie	17	44	12	2
Essex	3	4	3	0
Franklin	2	3	2	0
Fulton	2	3	1	0
Genesee	2	4	1	0
Greene	1	2	1	0
Hamilton	0	1	1	1
Herkimer	2	5	3	0
Jefferson	4	5	4	4
Lewis	1	1	1	0
Livingston	1	4	2	0
Madison	2	4	3	2
Monroe	8	35	15	6
Montgomery	2	4	1	0
Niagara	5	13	4	0
Oneida	5	19	3	0
Onondaga	4	13	5	1
Ontario	3	6	2	0
Orange	7	7	6	0
Orleans	2	4	2	1
Oswego	3	6	3	2
Otsego	2	3	6	0
Putnam	2	1	1	0
Rensselaer	3	9	2	0
St. Lawrence	5	8	1	1
Saratoga	2	3	2	0
Schenectady	4	5	6	1
Schoharie	1	1	1	0
Schuyler	1	1	1	1
Seneca	2	2	1	0
Steuben	3	4	1	0
Sullivan	2	4	2	0
Tioga	1	3	2	0
Tompkins	1	4	4	0
Ulster	3	5	5	0
Warren	1	4	4	5
Washington	2	4	1	0
Wayne	2	4	1	0
Wyoming	1	3	2	0
Yates	1	2	3	0

*Residential Helath Care Facilities include nursing homes and health related facilities.
**Receive Section 330 funds from the US Dep't of Health and Human Services for the care of indigent patients in medically underserved areas.

Sources: NYS Dep't of Health, 1986 Health Facilities Directory; and US Dep't of Health and Human Services, 1986 Directory of 330-Funded Community Health Centers.

Reconfiguring the Traditional Health Care Model

Symposium as well as public hearing participants noted the need to evaluate the current health care model and redesign it to more accurately reflect the reality of rural life. The traditional model is based on health care services delivery in metropolitan areas and consists of three distinct levels: primary, secondary, and tertiary.

"State policies must allow, even encourage, flexibility in regulations concerning agency staffing requirements and professional licensure restrictions. The regulations must be made relevant to rural needs and circumstances."

Ellen Kotlow
Home Care Association of NYS
January 1988 (Albany, NY)

The Metropolitan Model:

In metropolitan areas, primary care and preventive care are generally provided in physicians' offices or clinics. Services provided in these settings include diagnosis and treatment of uncomplicated illness and disease, minor surgery and medical care. In addition, these services are often provided through local public health or mental health departments, and include public health nursing services, immunization and home health care. Secondary medical services in metropolitan areas generally include medical and surgical diagnostic services for complicated illness and disease, emergency medical care, and specialized clinics. Most of these services are provided in relatively large community general hospitals. Specialized tertiary medical care is provided in large regional medical centers and affiliated facilities. Some examples of tertiary services are: specialized surgery, unusual and complicated surgery and dental care, and trauma care.

Finally, other highly specialized medical facilities have evolved to serve more limited purposes. These may occur in such service areas as maternity, rehabilitation, orthopedics, and care for specific age groups or clienteles. The institutions may encompass one or more of the three traditional levels of care.

The chart on the following page depicts these three levels of services, and describes them more fully.

The Rural Experience:

An issue that was continually raised during the symposium, and again in the public hearings, is that health care needs and services are notably different in rural areas. There is a greater need for family practice services than specialized services, for example. Similarly, small rural hospitals are not able to offer the range or specialization of services typical in metropolitan hospitals, nor is it necessary for them to do so. In addition, tertiary care is generally not available in rural areas but requires extensive travel and considerable expense for rural residents. Therefore, it has become clear that the model for rural health care must be altered to address the conditions and needs of the rural population.

Specific Reconfiguration Proposals:

Reconfiguration of the current model of health care delivery to assure its suitability to the rural situation will require regulatory flexibility and innovation. For example, the development of a mid-level of care would provide a stronger link between primary care and secondary care than currently exists. This intermediate level would include a greater emphasis on long term care, thus addressing the needs of a growing elderly population. It would feature

Traditional Health Care Model: Medical Care and Health Services Systems*

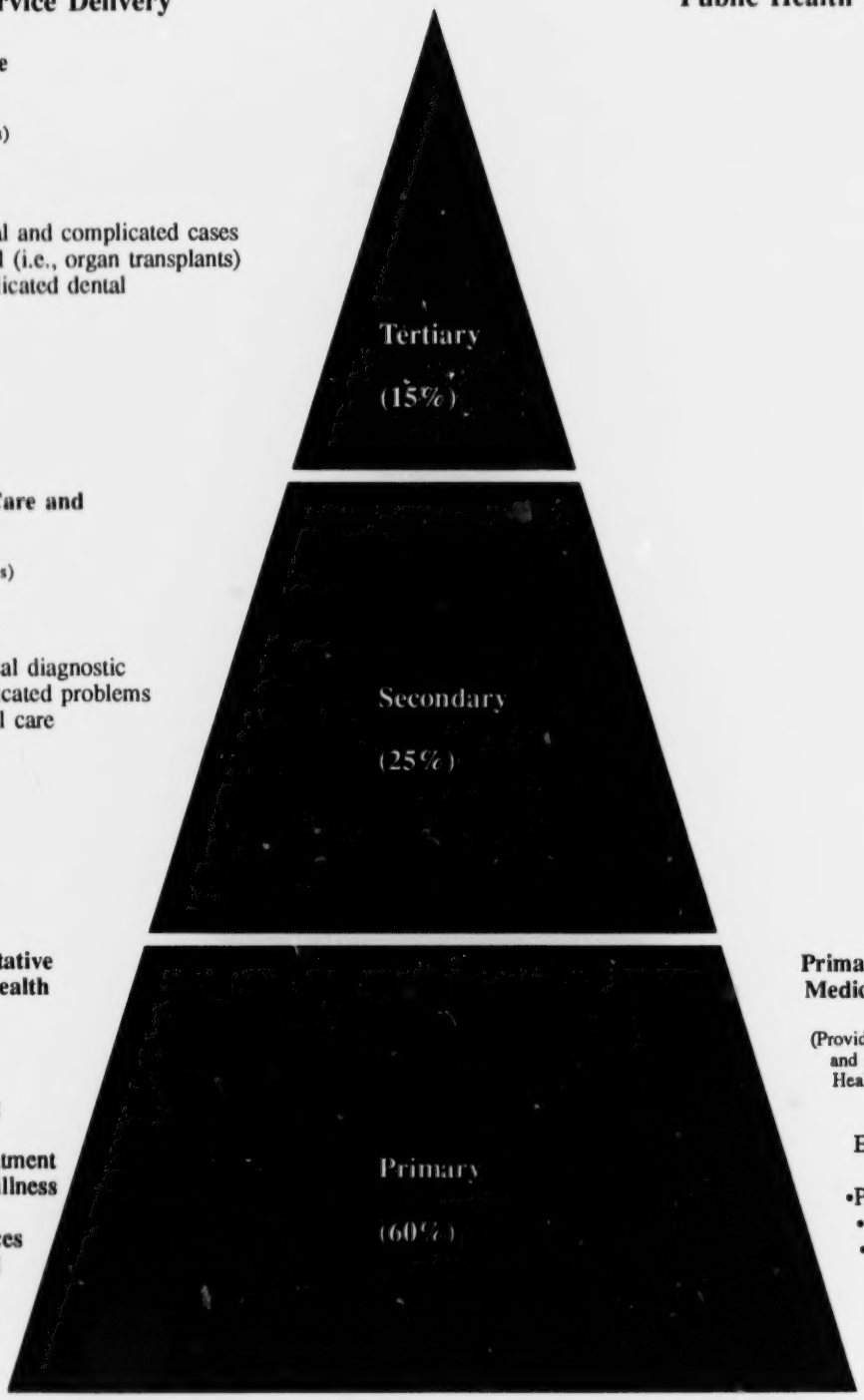
Percent of All Medical Care and Health Services Required in the Community

Private Health Service Delivery | **Public Health Service Delivery**

Tertiary Medical Care and Health Services
(Provided in large regional medical centers and affiliates)

Examples of Services:

- Specialized, unusual and complicated cases
- Specialized surgical (i.e., organ transplants)
- Unusual and complicated dental
- Trauma Center



Secondary Medical Care and Health Services
(Provided in large regional medical centers and affiliates)

Examples of Services:

- Medical and surgical diagnostic services for complicated problems
- Emergency medical care
- Specialized clinics

Primary and Preventative Medical Care and Health Services
(Provided in physicians' offices and clinics)

Examples of Services:

- Diagnosis and treatment of uncomplicated illness and disease
- Preventative services
- Minor surgery and medical care
- Home health care

Primary and Preventative Medical Care and Health Services
(Provided in public health clinics and other areas of local Public Health or Mental Health Dep't responsibilities)

Examples of Services:

- Public Health Nursing
- Environmental health
- Mental health clinics
- Immunization
- Home health

*Metropolitan Assumptions are Principal Focus

enhanced ambulatory care and surgery. In addition, it would address the need for broadened general services, and could include the use of existing facilities such as infirmaries for short-stay observation, convalescence and recovery. This level would also focus on the more routine types of inpatient care that comprise about 70 to 80 percent of all inpatient services. It might include the day hospital concept for specialty services, as well as the swing-bed concept. In the area of public health, closer links could be forged between all health-related care, particularly health screening, case management, and linkages with the human services delivery system. One of the most important aspects of this intermediate level of care is the coordination and integration of its various components.

"For the networking concept to succeed, substantial barriers to interagency cooperation would have to be removed at both the state and local levels."

Stoner Horey, M.D.
Rural Task Force
Finger Lakes HSA
November 1987 (Corning, NY)

Secondary care, in this new model, would feature more outreach specialty clinics provided by larger general purpose regional facilities at intermediate care sites. Improved linkages between all providers would be essential. Overall, the result may be a local Community Health Resource Center serving as an integrated component on the emerging health care continuum, and supported by larger secondary and tertiary facilities. On the public health side, this system would include improved emergency medical services system support; linkages, such as transportation and case management; and a new system of addressing the health care needs of the medically indigent.

Tertiary care in this reconfigured system would be offered in metropolitan or rural regional centers, but with improved linkages, in order to insure access to such care by rural residents. In addition, county public health departments might assume an expanded role, especially in developing and enhancing Medivac systems for trauma patients.

In a new rural model, health care must increasingly be viewed as a broadened, integrated continuum of health and health-related services. The elderly, in particular, need a broader range of services, some of which are only now being recognized and developed. The number and proportion of elderly persons in the population are steadily increasing, and are higher in rural areas than in metropolitan areas. Thus, rural health service delivery patterns must be reconfigured in order to meet the special needs of this expanding population group.

This new integrated system requires a local community-based network of health care and human services providers. The list would include, but not be limited to, the following: hospitals, skilled nursing facilities, and other health care facilities; local government agencies, such as social services, aging, and public health; private practitioners, including social workers, dentists, physicians and nurse practitioners; school systems and universities; community agencies, such as nutrition centers and adult day care programs; transportation; and other community organizations, including YMCAs/ YWCAs and community action agencies.

The chart on the following page depicts a hypothetical future continuum of rural health services ranging from medical to non-medical care.

New models, similar to the one described, would recognize the varied resources and strengths available in rural communities, while taking into consideration the special conditions under which providers must operate. The result would be a system of health care and human services delivery that would meet the needs of rural residents over the next two decades.

Future Continuum of Rural Health Services

Medical----------Non-Medical

Group I - Institutional

Acute Care: Tertiary, Secondary, Intermediate
Inpatient, Mental Health
Rehabilitation
Subacute/Stepdown, Swing Beds
Skilled Nursing Facility
Hospice
Day Hospital
Home Health Care
Outpatient Primary Care Clinics
Outpatient Specialty Clinics
(i.e., child/adult health specialty clinics)
Emergency Response Systems
Dental Care
Pharmacy, Other Specialties

Group II - Personal Care/Evaluation

Adult Day Care
Respite Care
Home Care
Health Assessment
Case Management
Health Screening
Adult Foster Care
Board and Care Homes
Assisted Living Apartments

Group II - Health/Wellness

Community Health Resource Center, Counseling
Health Promotion
Health Education
Caregiver Education
Congregate Meals, Meals-on-Wheels
Information and Referral
Community Environmental Health

Group IV - Support

Retirement Communities
Phone Reassurance
Friendly Visitor
Socialization
Transportation
Housing
Homemaker
Chore Services
Legal Planning
Financial Services

The future continuum of rural health services calls for an expanded range of services and strong linkages between all sectors of the community, including: health, education, training, social services, businesses, local government, housing, etc.

Workgroup Reports and Public Comment

Workgroup on System Framework, Senator John M. McHugh, presiding.

Each of the five workgroups suggested actions which would specifically address its assigned topic. Reactions to these recommendations were solicited during the public hearings held throughout the state. The findings of each workgroup are treated below, together with related comments that were sent to the Commission after release of a draft report on the symposium proceedings. The public comment is also briefly summarized.

Report of the Workgroup on System Framework —

Senator John M. McHugh; Moderator

One workgroup was assigned the task of making recommendations regarding the development of a framework for the rural health system of the next two decades. Guest faculty members Ira Moscovice and Bruce Amundson assisted in the preparation of this report:

The components of modern rural health and human service programs are multidisciplinary. This collaboration of services provides a continuum of child care from home to institution to community support programs and from newborn to child to adult/parent to the aged. New components to improve rural health care (such as swing beds and emergency facilities without acute care backup), however, will require legislation.

Design:

Each locale, through a local planning body, should implement a community health care model. The plan should be a well-coordinated community-based response, and not an institutional response. The hospital could continue to provide acute and emergency care as needed, but would act as a central hub for physicians and the allied health professionals of a variety of agencies. This design places primary emphasis on the need for *local planning and decision*

making. The design, though, must be coupled with state flexibility in administrative and regulatory guidelines so as to allow for: linkages, co-location of services, sharing of resources, cooperative training, and other coordination strategies.

Special emphasis should generally be placed on:

- The dramatic increase in persons over age 75 and age 85 who will require more chronic care. Thus, each locale must address the issue of how to provide health care and convalescent care in its own homes and community. Plans and legislation should be developed that will ensure funds for: recruitment, training and retention of home health care workers; the development of community-based services programs, such as the Department of Social Services' Enriched Housing Program, which provide assisted living to the elderly who don't require intensive health services, yet can't live independently in their own homes. The key in bringing appropriate health services to the frail elderly lies in better use of non-medical support services such as housekeeping, personal care, and the like.

- The high incidence of infant mortality and low birth weight in many rural areas. This could be done by increasing and/or targeting services for high school students, pregnant women and the fathers of their babies, and infant populations.

- The dilemmas faced in providing emergency care and services. Specifically, initiatives should be developed to allow counties, communities, and emergency providers to furnish adequate EMS care.

- The development of managed health care systems and other innovative delivery systems. These managed and innovative efforts would focus on better ways of providing cost-effective, high quality health care. An emphasis on preventive care, for example, is cost-effective in the long run, and the patient should be an active participant in his or her care.

- The improvement of primary care services in medically-underserved rural areas.

Components of an Ideal Rural Health Care Delivery System

- Central agency (hub)
  (i.e.) rural hospital or multi-service health clinic would include: a diagnostic treatment center, mental hygiene, ER services, lab facilities.

- Community personnel
  Police and fire department (sometimes lst responders).

- Outreach services (primary care)
  private and group medical practices;
  private and group nursing practices;
  professional EMS;
  free standing, out-patient departments (OPDs), and health centers;
  visiting nurse services (i.e., public health dept., private agencies);
  home health care agencies;
  nutrition - meals on wheels, congregate meal sites, social programs;
  mental health - outreach programs.

- Preventive health care
  utilizing educators, home health nurses, professional health providers, local agencies, nursing health associations, dairy councils, cooperative extension;
  regular screening for cancer, diabetes, etc;
  utilizing stationary facilities and also mobile units;
  family planning programs, especially for teens and adolescents, for addressing the growing teen pregnancy problem.

- Maternal and child health care services
  well baby clinics;
  prenatal-nutrition programs;
  early childhood intervention;
  educational programs focused on school age children (e.g., sex education, drug and alcohol abuse, nutrition, exercise) child abuse focus/counseling;
  pre-postnatal counseling;
  day care services;
  parent support groups.

- Adult health care
  educational programs in nutrition, exercise, medication abuse, retirement planning;
  support groups for specific diseases;
  mid-life crisis counseling;
  rehabilitation services (stroke and heart attack);
  treatment centers for alzheimers and other chronic conditions;
  hospice - grieving counseling;
  durable medical equipment for home care.

- Elderly services
  campus concept (home health care, LTC, HRF, retirement home, congregate living homes, apartments, day care centers, private homes, proprietary adult homes);
  respite services for both caregiver and the elderly;
  halfway houses for newly discharged patients who may need close supervision;
  geriatric assessment teams consisting of physician, nurse, and social worker to evaluate and direct the proper placement of dependent elderly;
  rehabilitative services;
  lifeline/link to life emergency service.

- Social
  all community social service agencies;
  informational telephone service (infoline);
  service organizations (Kiwanis, Elks, etc.).

"We find local planning at the grass roots level to be essential to the long-term acceptability of developed policy. Such planning should be initiated and directed by the local communities with direction from staff of the Department of Health who have rural interests."

Donald McIntyre
Supervisor, Town of Westport
September 1987
(Saranac Lake, NY)

The Community Health Services Delivery Body

Symposium participants emphasized that many rural communities experience major problems sustaining health services. This workgroup believes that each community should have the responsibility and resources to determine the spectrum of quality health and human services most suitable to and affordable by its residents. Therefore, we encourage and support efforts by interested and concerned communities or contiguous communities to develop plans that would establish an appropriate and comprehensive health delivery system for its service area.

- Initiation of process. (1) The Office of Rural Affairs (ORA) should encourage rural areas to create Community Health Services Development Bodies. (2) The ORA should aid the community or communities in determining: the local body's mission and purpose, the process, products, geographic boundaries of service area, composition (business providers, advocates, consumers), time frames, staff, and the roles of existing organizations or new ones. (3) The ORA should offer seed money to facilitate such health services development.

- Community response. (1) The community or communities notify the state that it will both develop a health system framework and facilitate its implementation. (2) the community or communities offer detailed steps as to how it will address change. (3) The community or communities commit to local contribution.

- The Community Health Services Delivery Body is created. (1) Staff is appropriated. (2) Board convenes local people to identify needs, resources, gaps, and strategies for addressing gaps. (3) Board regularly interacts with ORA and appropriate state agencies. ORA will serve as broker between locals and appropriate state agencies.

- Plan composition. (1) Plan is developed (i.e. needs, resources, gaps, strategies). (2) Needs and strategies are prioritized. (3) Plan is passed by planning body. (4) Plan is submitted to state.

- State-local agreement. (1) Local application is sent to state. (2) Application, with necessary and agreed upon modifications, is accepted. (3) Local group is designated by the state as the official body.

- Plan implementation. (1) Plan is implemented by community with assistance from ORA and other appropriate agencies.

Linkages

We need to focus on linkages at the local, state, and federal level with the public and private sector.

- Local level - public sector. A Community Health Services Delivery Body will coordinate with regional health planning agencies, relevant county health and human services agencies, and local development agencies.

- Local level - private sector. The Community Health Services Delivery Body may serve as a facilitator or catalyst to develop relationships within as well as external to the health care sector at the local level.
  a) Within health sector. Formal agreements, where appropriate, dealing with patient transfers, shared staffing, cooperative training, coalitions, cooperative and joint ventures, supervision, case management, and emergency services are examples of this approach.
  (b) External to health sector. Formal agreements, where appropriate, with local resources, businesses, education, finance institutions, and development agencies are illustrative of this approach.

- State Linkages. The State Office of Rural Affairs will serve as broker and ombudsman to appropriate state agencies involved with the development and delivery of health and human service components. The establishment of such linkages will be particularly important with respect to the Departments of Health, Social Services, Education, Transportation, Aging, Mental Health, and others having a direct impact on the delivery of rural health. It is particularly important to note that the NYS Legislature, through the Commission on Rural Resources and its mission and objectives with respect to outreach and liaison to appropriate standing committees, commissions, task forces, and legislative research affiliates, will be instrumental in providing necessary information to the Office of Rural Affairs as well as to local community groups and organizations in policy development. Further, the NYS Legislature will facilitate the development of professional health and other service-related programs to assure that the vital interests related to rural health system needs are being met.

- Federal Linkages. It is recommended that various state groups and individuals become members or affiliates of key national rural health care advocacy groups, in order to promote the interests of rural health providers and consumers from New York State at the national level. There are a variety of federal programs that may still be available for funding that address rural health care needs, i.e., National Public Health Service. The State Office of Rural Affairs will be the key liaison between local communities and federal agencies since it was the declared intent of the New York State Legislature, in the creation of the office, to have it assist rural communities gain access to federal funding sources in support of local program initiatives in such areas as health, human services, local government, economic development, transportation, and housing.

Delivery System - Recommendations

The Legislative Commission on Rural Resources should organize the conclusions of this symposium and seek integration or coordination with other groups (i.e., Office of Rural Affairs, Task Force on Rural Health Strategies) to seek favorable delivery systems for rural health care.

The system proposal should be understood to be a model reached by consensus of the broadly-based experiences of the participants and guest faculty. The purpose of the symposium has been to exhaustively exchange ideas and develop a framework, which then can receive further input through the processes deemed appropriate by the Commission (i.e. public hearings, a focused symposium). It is one model; it is not intended to solve all the ills, but certainly is conceived in such a way as to involve local/regional input and creativity by consumers and providers alike. It also strongly implies the cooperation of providers to come together, put aside vested interests

as best as possible, and develop a system responsive to their local/regional needs:

- Develop a resource bank for the purposes of study and for determining whether attributes of successful programs here and in other states can be replicated.

- Place a three-year moratorium on mandated rural hospital closures so as to permit development of system designs, as key components for a broad program.

- Utilize existing hospitals or other institutions as central health delivery hubs, uniting local providers in establishing a health services delivery campus or system tailored to meet local needs.

- Examine the elimination or waiver of regulations that complicate the provision of rural health services.

- Permit local coalitions the opportunity to reconfigure and develop the program structure for localized delivery. This may include items such as: streamline CON procedure; diagnostic and treatment center definition; Medicaid waivers; utilization of swing beds; provision of financing mechanisms for acceptable reconfigurations and system establishments; use of para-professionals (accrediting/licensing without compromising quality standards); respite.

- Existing providers must diversify and seek cooperative relationships with other providers in their locales to reach economies of scale in resource utilization.

- Encourage the Office of Rural Affairs to move aggressively to promote follow-up on the recommendations of the 1985 and 1987 Rural Health Care Symposia throughout the Executive Branch of state government.

- Ensure the provision of technical assistance to communities to aid in the planning and implementation of the health care delivery system.

Comments Received from Participants after Distribution of Draft Report:

- Questions: are the Community Health Services Development Bodies planning or delivery groups? If they are involved in service delivery, shouldn't they be under the direction of the Health Department? Answer: they are facilitative bodies, which can be involved in either planning or case management or both. The form the bodies take will differ depending on how they evolve in a given community.

- Point of information: Fulton County already has in place a Central Placement and Referral Agency for long term care. This entity has an advisory board above it. Possibly, this organization could be expanded to include all health care needs.

- Where is the process initiated? At the state level? Local level?

- Two additional strategies to address the problems of high infant mortality and low birth weight would be increased sex education programs, and having school nurse teachers in every public school.

- In developing managed health care systems, professional nurses have proved to be cost-effective.

- In utilizing rural hospitals or already existing facilities as the hub of service delivery, the emphasis should be placed on primary and preventive care.

Public Comment:

Comments received during the public hearings expressed clear support for the recommendations of the system framework workgroup. Several individuals noted case studies of providers moving ahead with diversification and sharing of services to reach economies of scale. The testimony reflected a belief that local health planning must focus on the needs and resources of a defined local area, and encouraged the development of a planning mechanism which reflects the needs and concerns of the community rather than the regulatory mandates of the state.

Workgroup on Access, Assemblyman Anthony J. Casale, presiding.

Report of the Workgroup on Access — *Assemblyman Anthony J. Casale; Moderator*

Emergency Medical Services

Appropriate access to the Rural Health Care System includes the availability of effective emergency medical services (EMS). The best emergency response system is of little use without a universally understood and quickly accessible method of requesting assistance. Therefore, a reliable communication is of critical impo.tance to EMS access. The 911 communication system should be developed and implemented throughout rural N.Y.S.

Quality EMS requires appropriately trained personnel. Current EMS systems are staffed primarily from a resources pool limited both in terms of available time and in numbers of trained personnel. The training problem is further compromised by recent decreases in training funds available to individual squads and for new recruits at a time when there are increased certification requirements, resulting in volunteers being discouraged, fewer in number, and more subject to burn-out. Funding is therefore needed to assist the volunteer component with training and if necessary to augment the volunteer core with paid staff, precedent for which exists in the fire services.

Appropriate equipment is necessary for the provision of quality EMS services. A program must be in place to make state of the art communication and resuscitation equipment available to EMS providers and to ensure that constant updating of this equipment occurs.

Effective EMS requires competent and consistent medical control. We must assure the presence of receiving facilities with personnel trained to provide quality medical back-up.

The increasing threat of liability in all phases of EMS poses a great concern to the future of the system. Risk management includes case review and continuing education, and these processes must be bettered. However, a review of the liability exposure of the EMS is critical to retention of participants.

"Access to health care is an everyday event. The distances to hospitals and specialists when needed for complicated care is a barrier. The short supply of health personnel, specifically physicians, is a major concern. We are finding it very difficult to attract and retain physicians even though we offer competitive salaries and benefits."

Nancy J. Bracken, M.P.A.
Oak Orchard Health Center
October 1987 (Albion, NY)

The volunteer, who is the keystone of rural EMS, should not be expected to solicit funds as the sole support of the system. Funds for equipment, uniforms, continuing education, and certification must become a public responsibility through subscribers, and all levels of government.

Primary Care

Key components of a health care system in a rural area are access to primary care and the personnel to provide it. This system in the next two decades should provide for a greater availability of an aggregate of providers. The increased recruitment and retention and the professional development of providers can be assured by the development of:

- Networks and group associations for all health professionals, and the basic diagnostic services to support them.
- Expanded graduate medical, nursing, and other health professional education in a rural setting.
- A new definition and scope of practice for mid-level practitioners.

Our group unanimously affirmed the proposition that every individual should have access to primary care. Access should be assured by:

- An adequate transportation/communication system.
- A system of payment which includes coverage for the elderly, the indigent, and the medically disenfranchised.

The primary care system should provide access to higher levels in the continuum of care with guarantees of return access to primary care through a coordinated two-way referral system.

We recognize that an integral part of primary care in rural areas includes access to coordinated and comprehensive community-based mental health services including:

- Mental health care
- Community residences
- Day programming
- Crisis intervention
- Special attention to the problems of children.

Hospital Care

Residents of rural communities identify the hospital as the focal point for their health care. Hospitals are critical to the community for health care, employment, and education, and are a part of the overall package of services which attracts people to the community to live and to work. While a continued role of the community hospital is required, current trends have modified the need for the type of services appropriately provided by the hospital.

The current environment provides incentives for hospitals to discharge sooner but requires a support system to provide alternative services for the total treatment of the patient. Rural communities must have a comprehensive system of alternative services such as home health, day care, etc. These services could be further developed utilizing existing hospital and community facilities.

In light of the identified focal point of the hospital and problems of the provision of needed services, it is recommended that the following approaches be implemented:

- Hospital resources should be converted to other uses in response to the health service needs of the community as an alternative to hospital closure.
- In order to accomplish the service modifications within rural hospitals, regulations should be modified to provide adequate flexibility required for the efficient provision of needed health care services. Examples of such flexibility are allowance for a varied mix of certified services (i.e., choice of providing emergency department services); multiple-use of beds for acute and chronic services; and the development of the infirmary concept.

Long Term Institutional Care
It is necessary to reassess the definition of financial coverage for clients to include the service provision for the chronically ill. There should be financial incentives to encourage admission of such client to facilities and promte enhanced service delivery.

With the increasing problems related to limited access to long term institutional care, encouragement of alternative methods of care are needed, such as community residences with ten or fewer clients receiving care with a strong family involvement as a major component.

A financing system for long term care is needed that will protect spouses and other family members from impoverishment if a family member enters institutional care.

Home Health Care
With the impact of the prospective payment system on hospitals, home health care has become a major player in the health care delivery system. In today's environment of shifting health care delivery to the most cost-effective and deinstitutionalized care, home health care fills the gap. We encourage a total commitment to home health care as the treatment of choice when possible. Home health, while a relatively new player in the system, has risen to every challenge put before it by expanding levels of skill to cover the spectrum from social support to home managed high tech care (IVs, Ventilators, Chemotherapy).

For the home health care system to function at its highest level we must upgrade and standardize Aides/Homemaker training and certification, with jurisdiction centralized at the state level through DOH. To maximize retention, creation of a career ladder including benefit options would be a major incentive.

Home health care can fill delivery gaps in rural areas. We must insist on quality assurance and commitment by those seeking certification not to exclude rural clients because of the additional costs involved (some proprietaries have been known to do this). We must also assure that access to home health care is not precluded by race, religion, or the ability to pay.

Health Education
Due to a lack of understanding of basic health care/wellness principles we feel the need to increase awareness of the importance of health education at all levels of society. Our priority would be to begin with the education of our children and those who are their role models/educators.

An obstacle identified in the educational system is requiring NYS teacher certification before a community health educator/provider could offer a health education course in public schools. A solution to this would be to change the certification requirements for health education in public schools. For example, a school nurse teacher may be able to meet such needs.

In order to have as many people in our society as possible knowledgeable about basic First Aid, require First Aid/CPR to be incorporated in health education curriculum. It is anticipated this would lead to a population that is better able to respond to emergency situations.

Due to major changes and shifts in the health care delivery system, people/ consumers do not understand how to access the system and how the changes affect them. The consumer needs to be made aware of what the system can and cannot do and what his or her responsibilities are within the health care system.

The idiom "An Ounce of Prevention is Worth a Pound of Cure" directly applies to educating the consumer on prevention issues. These issues include:

- Wellness
- Nutrition
- Safety at home/workplace

Emergency Medical Services

County Type	EMS Squads/ 10,000 Persons	Percent Volunteer Squads	EMTs/ Squad
Metro: 1	.32	69.71	35.01
2	.71	81.47	30.06
Rural: 3	.34	78.01	21.40
4	1.80	85.64	15.59
5	2.13	84.13	12.72
6	3.51	91.07	9.49

(See Appendix B for Explanation of County Types)

Rural areas have a high number of EMS squads. However, a greater proportion of these units are staffed by part-time volunteers in rural than in metropolitan areas. Also, the availability of Emergency Medical Technicians (EMTs) is much lower in such rural areas.

Methods need to be identified and developed to reach the consumers to educate towards changing attitudes and destructive behaviors.

One method the group identified to promote/motivate work place safety was to have the insurance industry offer financial incentives to consumers/employers who implement and demonstrate effective health/safety programs.

We also discussed the need to improve coordination and dissemination of safety program information through media, educational/service organizations, and be targeted toward specific rural health care needs such as the Farm Safety Program.

Public Health

Public Health practice encompasses many professional disciplines which must be acutely responsive to the needs of society presently and prospectively. Since the scope of public health is very broad, there must be effective coordination of epidemiological case findings, health education, and environmental health. This need was identified in the promulgation of Article VI State Aid which promotes coordination of public health services, community health assessment and delivery of basic public health services. The current Article VI State Aid fosters the development of local health departments and provides programmatic and financial opportunities.

A shift of responsibility from state to local government improves responsiveness to issues due to local awareness and community identification of their public health concerns. The regulatory functions of public health can only be fulfilled with adequate resource provisions.

Uniform access to prenatal care, family planning and well-child clinics is a basic human right. Barriers of any type must be eliminated.

Safeguarding all child populations against communicable diseases such as measles, mumps, and polio, has been established and proven effective. Adequate vaccine levels must be assured for counties to maintain total child immunization.

AIDS is recognized as the No. 1 health problem facing our society. Resources must be appropriated to regionalize the

responsiveness of AIDS education/ intervention to manage this illness as a public health disease.

Support Services

In an effort to promote effective communication between health and human service providers and consumers, it is necessary to have a comprehensive system of information and referral. This system will be comprised of a toll-free number operated on a twenty-four hour basis and staffed by trained personnel. The system requires adequate, modern communication equipment to be effective. Marketing of this central point of access to services through widespread promotion and publicity is key to its success.

In order to promote the availability of health insurance coverage for all rural N.Y.S. residents, including the working poor, health insurance carriers must be given incentives to make insurance packages more comprehensive and affordable.

In order for quality health and human services to be delivered effectively, access to these services through adequate transportation (public/private) must be available. It is necessary to remove regulatory barriers from accessing existing agency vehicles, such as OFA and ARC vans, school buses, etc., to maximize their potential for transportation needs. In light of the limitations of the existing rural public transportation system, it is necessary to explore new transportation models with adequate funding.

Another barrier to accessing support services is lack of understanding of the health and human service system by the consumer and/or significant others. A client-centered case management system with a lead agency designated as responsible for ensuring that appropriate services are accessed with follow-up must be implemented.

Part of support services includes accessing adequate shelter so that a decent, safe and sanitary living environment is available to residents of rural New York. It is critical when home care is the care of choice and the home is the focus of service provision. Adequate funding for appropriate rural housing development is necessary.

Rehabilitative services, including PT, OT, speech, etc., are oftentimes nonexistent or limited in rural areas, due to lack of trained professionals. Recruitment, retention, and local education programs must be developed to alleviate this problem. Also important is the coordination and integration of rehabilitative services with other health and support services such as vocational, job training, and job placement.

Comments Received from Participants after Distribution of Draft Report:

- The reference made to a decrease in funding for emergency medical services training may not be accurate.
- When a hospital is the only provider in the community, it should be required to provide emergency services. However, if there is an alternative provider for emergency services, the hospital should have the option to provide emergency services.
- Freestanding emergency services providers should not be required to provide acute care beds.
- Flexibility is needed in the assignment of beds. The administrator should have the prerogative to assign beds as acute and/or long term as demand dictates.
- The definitions of mid-level practitioner, physician's assistant, and nurse practitioner need to be defined more broadly with an expanded role.
- Nurses feel that a new definition is not needed for "nurses."
- It is imperative that access for the medically indigent to a full scope of services be assured.

- "Uniform access to family planning" should be changed to "no prohibition of access to family planning."

- Home care does not speak to capacity problems. Areas that need to be reviewed are: public need methodologies and restrictions on access.

- Investigate N.Y. regulatory requirements that are in excess of federal requirements.

- Despite its potential to improve access to primary care, the Rural Health Clinics Act (RHC) has only been minimally implemented in New York State. This lack of implementation is due to the excessive clinic certification requirements instituted by the Department of Health. The Office of Rural Affairs should investigate the RHC certification process implemented by the Department of Health and seek a certification process that is no more restrictive than that required by federal regulation.

- The 911 communication system for emergency medical services should be free of charge to rural residents. Telephone companies should be encouraged to contribute to the development and continuance of this system.

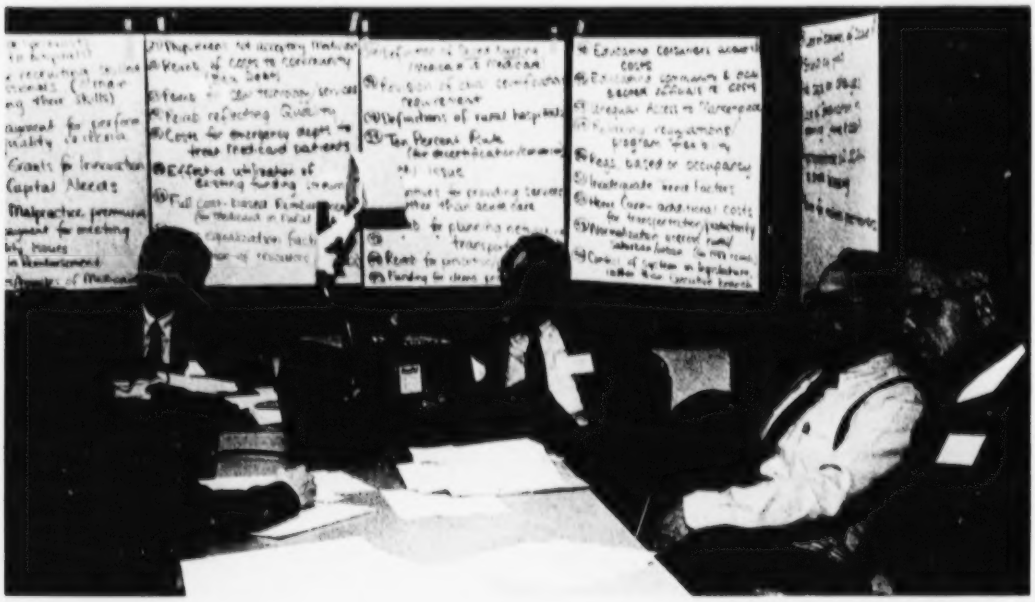
- Current reimbursement systems do not adequately cover home health services, and the proposed NYS methodology called "PATH' may have negative effects on CHHAs.

- Increased utilization of professional nursing services is an effective and efficient means of ensuring access to public health services such as prenatal care, family planning, and well-child clinics for all rural residents.

Public Comment:
Testimony during the public hearings highlighted the need for access to support services, such as transportation and housing, in addition to traditional health care services. Several speakers addressed the need for housing alternatives for the elderly, such as continuing care communities where elderly individuals live independently, yet receive needed services in the home and at nearby health service facilities. There was also a heavy emphasis on problems encountered by the emergency medical services system, including: a lack of training and education for volunteer workers in the community; excessive costs in terms of time and travel for the training of volunteers; state regulations which preclude the use of non-EMT squads in cases where reaction time is of utmost importance; and particularly the lack of a strong state commitment to EMS.

"How far is too far to receive health care? A ruler on the map can count the distance the way the crow flies or miles on a odometer can measure a certain range of distance, but it actually depends on how long it takes for a person to drive from one point to another to determine how far away health care actually is — if that person can, indeed, drive."

Joyce Powell
Greene Co. Dept. for the Aging
December 1987 (Schoharie, NY)



Workgroup on Reimbursement, Assemblyman William L. Parment, presiding.

Report of the Workgroup on Reimbursement —

Assemblyman William L. Parment; Moderator

Steven Rosenberg and James Scott, members of the guest faculty, guided the discussions on reimbursement and finance, and provided feedback on the group's recommendations:

The reimbursement workshop group perceives that the delivery of adequate rural health care services requires the development of reimbursement strategies that would be sensitive to the unique characteristics and needs of rural health care providers. Based on this consensus, the committee recommends that, in the long term, the following types of reimbursement systems be examined to determine their ability to address the needs of the rural health care system:

- Case Mix System — Characteristics: All payor; PPS; All services; Clinical Criteria (e.g., DRG); CON optional
- Block Grant System — Characteristics: Pilot; Capped, but guaranteed revenue trended; No CON; Savings go back to community; 3 to 5 year term; All providers; All services, Geographic
- Market Model System — Characteristics: Consumer driven; No CON; No franchise on services; ADS products (e.g., HMOs, IPA, PPO, traditional insurance); Supply and demand; For-profits compete; All services

There was a lack of consensus on which alternative would be most appropriate, with one member choosing the Case Mix system; 2 opting for Block Grants; 3 for the Market Model; and 4 choosing to adjust the current system. (The rest of the group either had no opinion or abstained from expressing one.)

The group felt that, in general, information regarding these types of reimbursement systems and their respective impacts on the delivery of health care in rural areas is lacking. Therefore, they felt that a budget appropriation should be made available to the Commission on Rural Resources to fund

a study by private group(s) to research, analyze, and develop these models.

The group also felt that it would be more appropriate for them to concentrate on immediate, short-term considerations and recommendations.

"As I see New York State now, it is so over-regulated by the health care bureaucracy, it is not only an unfavorable climate for physicians, it is fast becoming an unfavorable area for health care executives. The regulatory environment is so oppressive that the operating experience one gets here as opposed to less regulated states is simply less attractive."

Kevin Carroll
Champlain Valley Physicians Hospital, September 1987 (Saranac Lake, NY)

Short-term (Priority) Recommendations:

- There should be a moratorium on involuntary closings of hospitals in rural areas for two years.
- The Commissioner shall provide regulatory flexibility in the areas of licensing, certification, and code compliance for health care providers in rural areas, as current regulations and codes have a negative impact on rural facilities and providers.

It is recommended that the following issues should be incorporated into post-1987 reimbursement system(s):

- Consideration should be given in statewide planning to ensure that negative impacts are not imposed on rural providers as a result of their geographic location.
- Wage equalization factors should be developed with recognition that rural hospitals must compete in employment markets with urban hospitals, as well as in state labor markets.
- Rural RHCFs should have facility-specific wage equalization factors, rather than regional factors.
- The Medicaid system should include appropriate reimbursement for providing home health care and case management in rural areas, recognizing the efficiency problems of distance and population sparsity.
- The state should adopt a more hospital-specific reimbursement methodology rather than a pure-price blend.
- The state should pay for transportation to and from health care facilities, for the elderly and other individuals unable to drive or without a vehicle or access to public transportation, when the services are under a physician's order.
- The state should allow and pay for rural hospitals to provide interhospital patient transport services themselves without requiring the approval of Regional Emergency Medical Services Councils.
- When reimbursement rates are set, there should be recognition of fixed costs and stand-by costs incurred by rural hospitals.
- An appropriate appeals process is needed for reimbursement of extraordinary costs incurred by rural providers.
- The use of charge control as a regulatory mechanism should be eliminated, and charges should be set solely by providers, based on a free market system.
- Reimbursement is needed specifically to encourage rural health care providers to develop and expand preventive health programs at both the hospital and community levels.
- Mechanisms must be developed for third-party reimbursement of mid-level practitioners (e.g., PA's, Nurse Practitioners) in rural areas.
- A waiver of the CON process for rural hospitals to allow a plus or minus ten percent change in certified bed capacity, on a temporary basis, should be adopted.
- Regulations should be adopted wherein RHCFs can appeal for relief from RUGs Medicaid Rate ceilings on the basis of unique, rural, non-patient, facility characteristics and costs, where lack of such relief would jeopardize the continued provision of SNF/HRF services in the rural community. Approval of such appeals should be required within six months.

- Rural RHCFs should be allowed the option of voluntary participation in Medicare.

- Regulations should include requirements that appeals for extraordinary costs by rural providers will be processed in thirty days or will be automatically approved. Furthermore, delays in the payment of approved rates beyond thirty days from approval shall require the payment of current rates of interest.

- In addition to appeals submitted in accordance with approved regulations and mechanisms, regulations should allow appeals submitted for increases in operating costs in excess of base year levels trended/approved rate levels for programs such as outreach, education, etc.

- A rural-oriented capital pool should be established which would provide loans to rural providers at reasonable cost of capital. Specifically, lending methods should not require letters of credit and other extraordinary costs of the transaction.

- The Legislature should require the NYS Department of Health to clearly designate staff to assist rural health care providers on a consultative basis to comply with the Department's regulations.

- Funding should be provided by the state to staff a technical advisory group to assist rural health providers. This advisory group should be established as part of the State Office of Rural Affairs.

Reimbursement: Major Issues and Concerns

The workshop group on reimbursement identified sixty issues and concerns that they felt should be addressed. Some overlap existed in these issues, and they were categorized into five main groups: (1) Inequity; (2) Flexibility; (3) Currency and Timeliness; (4) Appropriateness; and (5) Complexity.

Inequity: Major problems for rural providers are inequities in reimbursement rates, and lack of recognition of unique rural costs and conditions in establishing those rates. Specifically:

- Inconsistency of Federal and State definitions of "rural" and "urban"

- Urban/Rural rate differences
  - Physicians not accepting Medicaid
  - Inability to provide some services due to lower rural rates

- Unique rural costs/conditions
  - Lack of economies of scale
  - Standby fees: rural vs. urban

- Unequal access to marketplace
- Different rates for different departments
- Higher medical malpractice premiums

Flexibility: Flexibility in several areas was identified as important. Specifically:

- Need for flexibility to meet needs of different providers

- Program flexibility/relaxing regulations

Currency/Timeliness: These time frame and currency (i.e., re: base years) aspects of reimbursement were also considered important:

- Currency in reimbursement
- CON issue
- Time frame for grant proposals

Appropriateness: Many aspects of reimbursement identified as concerns fit under the category of appropriateness. These include:

- Incentives
  - Payment incentives should be used, rather than penalties
  - Incentive payments for performance vs. quality criteria
  - Incentives for providing services other than acute care
  - Incentives for specialists

- Payments for providers and services
  - Paying hospitals for recruiting physicians and other medical professionals (e.g., registered professional nurses), and for assisting them in establishing and maintaining their practices
  - Case management fees
  - Reimbursement for mid-level practitioners
  - Payments for innovative projects
  - Meeting capital needs
- Appropriateness of JCAH vs. state licensing
- Definition of "skilled nursing" (Medicaid vs. Medicare)
- Appropriateness of regulations based on occupancy
- Inadequate trend factor

Complexity: The abundance and complexity of fiscal management/paperwork are considered problems. In particular:

- Paperwork complexity and duplication
- Lack of reporting capabilities
- Lack of coordination in regional planning
- Educating consumers regarding costs
- Educating the community and local officials about costs

Comments Received from Participants after Distribution of Draft Report:

- Payments resulting from appeals should be paid in dollars, not as adjustments to the next year's rates.

- Payments for transportation in rural areas should not encourage provision of transportation services solely for access to health care, but rather a coordinated system of transportation for many other purposes.

- Waivers of rate ceilings should be for all rural health care providers, not just for skilled nursing facilities.

- Many of the issues and recommendations the workgroup identified are really of a national scope (e.g., optional participation in Medicare). Current activities in Washington will affect the ability of NYS to adequately address such issues.

- The proposed reimbursement methodology for home health care is a pricing system similar to RUGs. There is universal concern that the methodology will cause irreparable damage to Home Health Agencies (especially public). At this critical time, additional demands are being placed on public agencies. The proposed system should be thoroughly modified before implementation by NYS DOH.

- Some feel that the moratorium on involuntary hospital closings should be for three (3) years, instead of two.

- The recommendation for regulatory flexibility on the part of the Commissioner led to the comment that standards should be developed that meet unique rural conditions and needs, but still ensure quality of care.

Public Comment:

The public comments received concerning reimbursement and financing focused primarily on problems with federal reimbursement systems and the need for adequate funding of non-institutional care. The new post-1987 hospital inpatient reimbursement system for New York State was agreed upon in the fall of 1987, but was not passed by the Legislature until January 1988. Therefore, few speakers were able to respond to inquiries as to the impact of the new system on their individual facilities. A great deal of concern was expressed regarding the inadequacy of reimbursement for home health care in rural areas, where extensive travel is required and generates increased costs for personnel and transportation. Funding for the mid-level practitioners was also mentioned as an issue for addtional study. Providing third-party reimbursement for mid-level practitioners would grant rural providers the opportunity to utilize these professionals more efficiently, and reduce the necessity of maintaining an overqualified staff for more routine care.

Workgroup on Personnel, Assemblyman John G.A. O'Neil, presiding.

Report of the Workgroup on Personnel —

Assemblyman John G. A. O'Neil - Moderator

Uncertainty

In addressing the issue of personnel, with specific focus on recruitment and retention, the concept "uncertainty" in the rural health care environment was identified as a primary concern. The concept manifests itself in a number of ways. Those areas of "uncertainty" identified as priorities are: 1) reimbursement; 2) malpractice and tort reform; 3) more planning and coordination between Department of Health (DOH) and local communities, especially as decisions impact on personnel; and 4) utilization of the state Office of Rural Affairs as a clearinghouse and ombudsman for information and technical assistance.

Current reimbursement policies result in an uncertainty with respect to recruitment and retention of professionals serving in rural areas. Changes needed to resolve this problem include:

- Mandatory third-party reimbursement for professional nursing services.
- Modification of current charge control restrictions to allow hospitals to increase their revenue stream to enhance personnel salaries and benefits.
- More advanced notice of new rules and regulations in order to accommodate and design personnel changes.
- Developing incentives (e.g., third-party reimbursement methodologies) for providing preventive and primary care.

The unavailability and cost of malpractice insurance have had a detrimental effect on the recruitment and retention of health care providers. The high cost of this insurance has a disproportionate impact on rural providers whose compensation is lower than urban counterparts. Tort reform is needed to resolve this issue.

The department of health and the regional health systems agencies should coordinate with local hospitals regarding planning decisions impacting future viability in order to accommodate job continuity and alternative career paths.

The Office of Rural Affairs should facilitate the development of consortia of health care providers in rural areas to evaluate the social and healthcare needs of the community, perform economic impact assessments, and to provide technical assistance where appropriate. Addressing these issues of uncertainty through legislative and regulatory initiatives will foster a more positive environment in rural areas for health care professionals.

"We're not only struggling locally with nursing shortages, R.N. shortages, but we have trouble recruiting medical technicians, X-ray technicians, laboratory technicians, physical therapists."

Timothy Sweeney
Community Hospital
of Schoharie County
December 1987 (Schoharie, NY)

Isolation

In order to recruit and retain professionals and para-professionals in rural areas, the unique isolation characteristic of rural settings needs to be taken into account.

Lack of collegial relationships could be ameliorated by encouraging networking though telecommunications and regional professional groups.

In rural areas, the burden of frequently being the only available provider, constantly on call, increases the sense of isolation. A system of *locum tenens* should be encouraged and possibly coordinated on a county or regional level.

Allowing more flexible practice patterns by implementing changes such as increased supervisory visits should decrease the isolation experienced by the individual practitioner and should also result in better retention of personnel.

There are problems inherent in rural service delivery that lead to retention difficulties. Communities recruiting health personnel should undertake efforts in advance to re-educate the host community as to appropriate levels of expectation and also educate prospective providers to isolation problems and how they could unite to effect necessary change. For communities unable to do this, the state through an office of "rural health" should design a formal recruitment-retention program for rural areas.

Inflexibility

Federal and state regulations, such as hospital staffing requirements and professional licensure restrictions, lack sufficient flexibility and relevance to rural health care needs. For instance, administrative nursing personnel in hospitals and home health agencies are often excluded from giving patient care. There are mandatory minimum staffing and credentialling requirements that are likewise inappropriate. The lack of credentialled staff results in inadequate reimbursement for those who do perform the functions but lack the required credential.

Lack of third-party coverage for services performed by registered nurses in general, PAs, and nurse anesthetists significantly impedes the proper utilization of these mid-level providers in meeting rural health care needs. This is both a federal (Medicare) and state (Medicaid and private) problem.

With a limited patient base and inability to achieve economies of scale, rural health services struggle to maintain a full complement of fully licensed allied health practitioners.

Inadequate statutory definitions of some mid-level practitioners (e.g., PAs, NPs and nurse anesthetists) impedes their utilization in meeting rural health care needs.

An Office of Rural Health should be created within the Office of Rural Affairs which would serve as an advocate and ombudsman for rural health interests. Its functions should include serving as a clearinghouse of health regulation information for providers and consumers, providing technical assistance to rural communities in need of assessment, planning and implementation of health care services, and staffing a rural health council. The rural health council would be charged with reviewing existing and proposed laws and regulations for their appropriateness to rural areas and with advising state government on the impact of regulation on rural health care delivery. There should be legislation passed which mandates third party reimbursement for services provided by NPs, nurse anesthetists and PAs. Relevant statutes should be amended to provide clear definition of the

credentialling requirements and scope of practice of mid-level practitioners.

Socio-Economic Status

The socio-economic realities of rural life often serve as deterrents for the recruitment and retention of highly educated health professionals whose training has "socialized" them to favor the cultural, economic, and educational opportunities of urban life. Some of these discrepancies might well be addressed by more appropriate education for these professionals (and those who teach them) to remove the stigma of second class status traditionally assigned to locating in rural areas.

Perhaps more importantly, the traditional economic disincentives associated with rural life for health care workers need to be reversed. The assumptions inherent in federal (Medicare) and third-party reimbursement fee structures that continue to disfavor rural areas serve to decrease wages for all levels of health care professionals and make recruitment and retention of those personnel more difficult. The current skewing of insurance coverage towards inpatient and high-tech medical care, with lack of reimbursement for preventive, primary and home care services, leaves rural residents largely unable to afford the types of services that primary care providers deliver best. These are the services that are widely endorsed by health care planning bodies, academicians and legislators as the most appropriate ones for rural areas; but little insurance money has been forthcoming to help pay for these services.

The historical reliance on volunteerism for the delivery of emergency medical services is a fragile method of maintaining a cornerstone of rural health care delivery. Incentives to voluntary E.M.T.s should be provided by state and federal tax credits that liberally recognize the labor provided by these individuals.

Finally, the economic life of rural communities needs economic revitalization programs. When this is achieved, all members of rural communities will benefit.

Regional Training

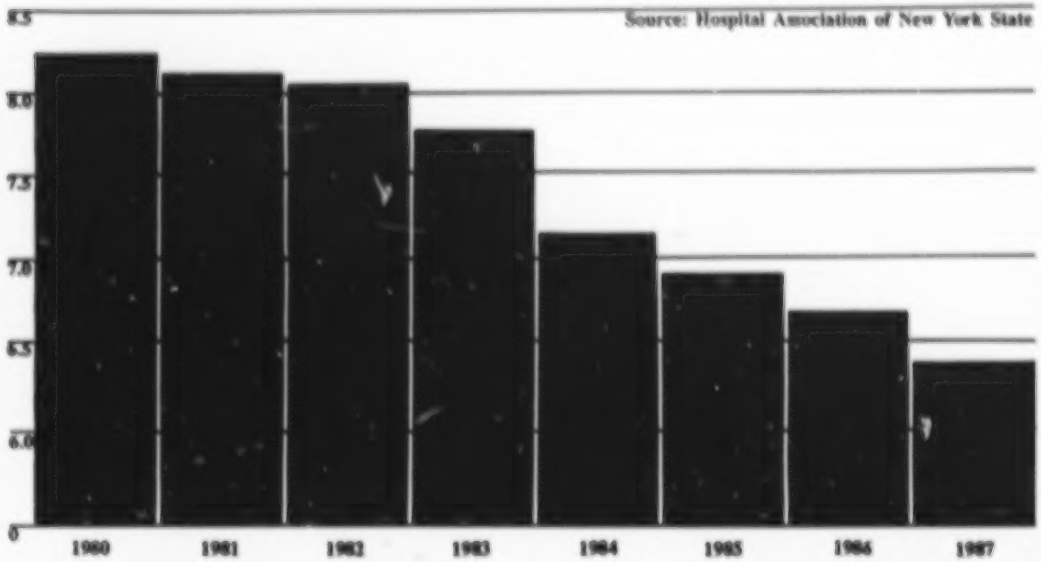
The concepts presented in this section are based on the premise that the Office of Rural Affairs will monitor and implement suggestions made within this area.

It was recognized by the committee that rural health training is inadequate as a means of promoting recruitment and retention.

The basis for recruitment and retention is improved education of what RURAL HEALTH is to the general public. There is a need for increasing awareness among students of the many opportunities for a career in the health care professions. Guidance counselors can be an excellent resource, given the appropriate knowledge, to motivate and direct students into health-related careers. We encourage students in K-12 to be increasingly exposed to the educational opportunities and role models of health professionals at all levels. This could be accomplished through such programs as:

- volunteer - candy stripers
- part-time student work experience
- clinical experiences through summer internships
- The state should explore the possibilities of creating a pool through its Department of Labor of employable applicants interested in health related employment.
- Job Training and Partnership Act (JTPA), funds could possibly be used to fund on-the-job-training for home health aides on a full-time and part-time basis.
- We should capitalize on our strengths and recruit local individuals who are familiar with the lifestyles of rural residents. One way to achieve this is to offer incentives. Across the board incentives could be provided for individuals coming from urban to rural areas. Examples would

Graduates from RN Teaching Programs in New York State, 1980-87 (in thousands)



With few exceptions, New York colleges with programs in registered nursing are producing far fewer RNs now than in 1980. Scholarships, guaranteed employment and other inducements in recent years have not helped increase RN enrollment sufficiently to meet current and future demand.

include loan forgiveness programs for health professionals who practice in rural areas and grants/scholarships for students.

- There is a need to encourage the use of workstudy stipends and grants for low-income individuals for the training of para-professionals. The para-professional will, in turn, serve in a rural or other underserved community health center.

In the area of education the ideas presented by the committee will assist both recruitment and retention. The following ideas are suggested for implementation:

- Training institutions should be encouraged to provide clinical experiences in rural and other underserved communities. This should be done in a comprehensive manner to encourage "positive clinical experiences" for students.

- Opportunities should be made available through cooperation between the health care professions, multi-level educational institutions and health care providers to promote entry of rural individuals into the health professions. Make available ongoing career ladders (e.g., LPN to Associate Degree Nurse to Baccalaureate Degree Nurse), with appropriate incentives to move upward. Ideally the long term goal would be the standardization of the educational level for professional nursing practice at the B.S. level.

- NYS should explore the development of the Area Health Education Centers (AHECs) which should function on a regional basis to address the educational needs of health care providers and of students. AHECs should be to:

- Develop rural education training sites for multiple disciplines.
- Develop and coordinate continuing education for multiple disciplines.
- Foster educational linkages between major medical centers and rural health providers.
- Encourage the involvement of local colleges and universities in continuing health education.
- Develop and make use of interactive communications technology for the purpose of continuing education.
- Encourage research on rural health delivery.

Conclusion:
In developing these recommendations, the group did not have sufficient time to separate them into short and long-range solutions. The next step should be to select those which are "doable" within the next year and seek their implementation. Those which require more indepth analysis, should be reviewed with a process set in motion to carry them to fruition.

The legislature, executive branch, educational institutions and providers must collectively and diligently pursue these objectives; an absence of highly qualified and motivated professionals will leave rural NYS with inadequate health care.

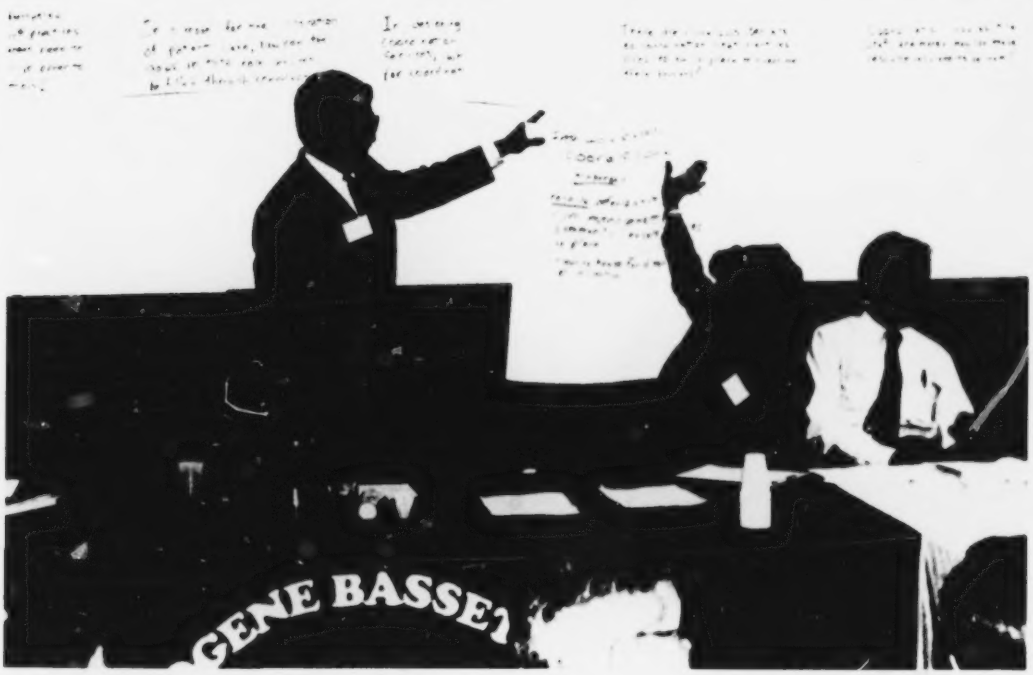
"Our largest staffing problem is critical care trained registered nurses, and they have been extremely difficult to both recruit and retain. Part of the problem in retention is we have moved from a local market on critical care to a regional, if not statewide, market."

Sister Mary Croghan
St. Francis Hospital
November 1987 (Corning, NY)

Comments Received from Participants after Distribution of Draft Report:

- Create incentives to encourage urban medical teaching facilities to place physicians in rural areas.
- Strengthen programs offered by SUNY system dealing with rural issues.
- Create additional rural training sites and facilities.
- Concern over inflexibility of regulations should not result in lowering standards for rural health, since the quality of the care must be ensured.
- Concern expressed over creating another layer of bureaucracy (i.e., an Office of Rural Health) because it may result in more regulation, more delays, etc.
- The premise of the section on regional training alternatives may be inadequate, since the State Office of Rural Affairs does not have the authority to implement many of the recommendations.
- The recommendation to develop new Area Health Education Centers may not be necessary. Currently existing facilities, such as community colleges and SUNY campuses, and BOCES centers, may be networked to carry out those suggestions.

Public Comment:
The public comment received in the area of personnel highlighted some of the points raised in the workshop discussion, especially those regarding reimbursement for health care professionals. Speakers urged additional third party reimbursement for mid-level practitioners, and incentives for innovative utilization of health care professionals. In addition, a number of those testifying cited the need for a competitive edge in order to recruit and retain the necessary personnel. They noted great difficulty competing with the urban areas which have traditionally received greater reimbursement for personnel costs.



Workgroup on Coordination, Senator James L. Seward, presiding.

Report of the Workgroup on Coordination —

Senator James L. Seward; Moderator

"The Department of Health, Department of Education, Labor Department, Department of Social Services, Office for the Aging ... all have their regulations and policies ... we often forget that we are all serving the public consumer in some way. We need more cooperation to deliver services."

Dorothy Madden
Essex County Nursing Service
September 1987
(Saranac Lake, NY)

The lack of adequate coordination among agencies and professionals is a serious impediment to the provision of health and human services. Since the broad spectrum of coordination required to address this problem is statewide, the implications of state policies should be assessed by a state agency - the State Office of Rural Affairs. The workgroup on Coordination identified the following as some of the problems affecting coordination among rural providers:

- Lack of consumer, provider and regulatory information on available services and programs;
- Legal and regulatory restraints;
- Inconsistencies in the regulations and their interpretation;
- Ambiguous or contradictory definitions and terminologies between service providers, and between agencies that regulate them;
- Geographic isolation of service providers;
- Maintenance of patient/provider confidentiality, as it may impair the sharing of information;
- Inadequate transportation systems to provide client access;
- Concern among local providers over possible loss of autonomy and control;
- Need for enhancing management skills at the local level;
- Lack of availability and accessibility of needed services;
- Shortage of skilled workforce;

- Limited resources at the local level;
- Nonexistent or limited linkages, and gaps between federal, state, and local governments, priorities, resources, and agencies.

The workshop recognized that these and other problems of coordination could not be solved in the short time of their deliberations. The workshop recognized that coordination must be initiated on the local level but at the same time believed there is a need for incentives to be offered by the state to facilitate the development of local programs. The workshop proposes the creation of a Council for Rural Health and Human Resources under the auspices of the New York State Office of Rural Affairs. The Council would oversee the administration and awarding of substantial multi-year grants for the development and implementation of Local Rural Health and Human Services Coordinating Councils.

"The concept of BOCES ... seems to be locally-sanctioned, state-sanctioned, and allows the small rural school systems to bring to them resources and services they cannot necessarily afford or attract themselves ... I would think that consideration of some system of that sort in [rural health care] would be very helpful and would help rural areas maintain that rural ethic of self-determination or at least some bit of self-direction."

Scott Parisella
Salamanca District Hospital
November 1987 (Corning, NY)

The Council for Rural Health and Human Resources will be given the following powers and responsibilities. It will receive, review and approve applications to establish local councils and provide adequate funding. The Council will also review regulations and statutes affecting rural health and suggest appropriate changes at the state level. In addition, it will be responsible for informing local councils and providers of issues affecting them. The statute establishing the Council could provide that the Council be charged with proposing appropriate waivers of statutes and regulations interfering with delivery of coordinated health care. In addition to the functions and responsibilities outlined above, the Council will be required to report at least annually to the Legislature and the Governor. The Council will be a clearinghouse for all requests for waivers originating with local councils or providers.

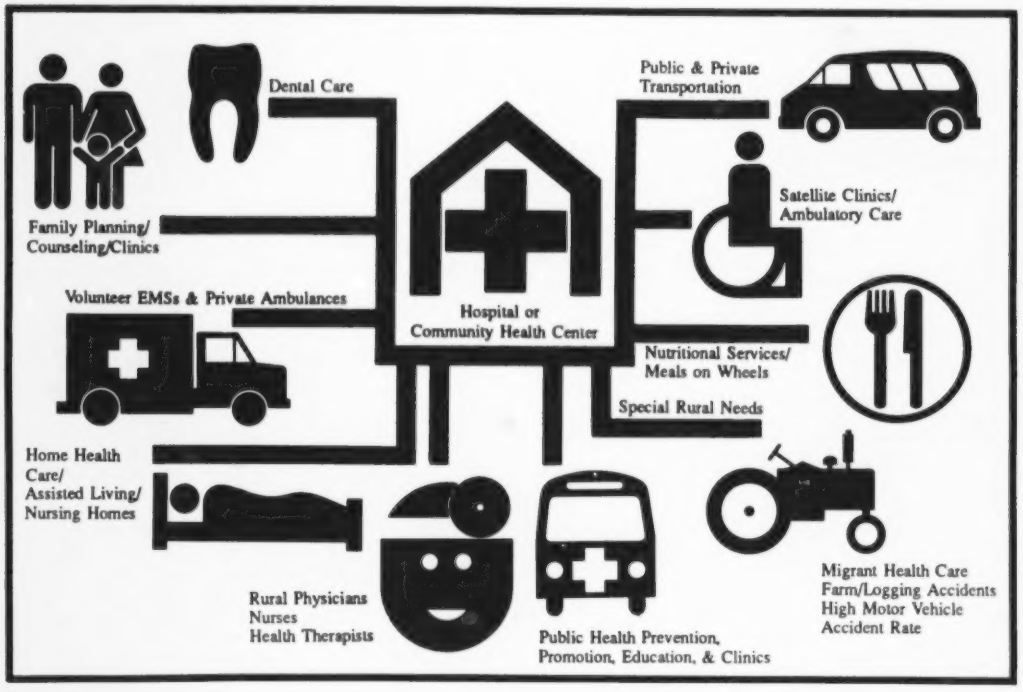
The Council will consist of the following or their designees: the Commissioner of Health, Commission of Social Services, Commissioner of OMRDD, Commissioner of the Office for the Aging, Commissioner of Housing, Commissioner of Education, and an equal number of public members selected from residents, providers and local council members.

Ideally, Local Coordinating Councils would be representative of, but not limited to the following local health and human service providers:

Department of Social Services
Hospitals
Pharmacists
Mental Health Clinics
Area Office for the Aging
Physicians and other Clinicians
Schools
Colleges
Public Health Departments
Health Maintenance Organizations
Churches
Transportation Providers
Interested Consumers
Emergency Medical Care Providers
Clinics
Dentists
Visiting Nurses
Retired Volunteer Service Programs
Social Workers
YMCA/YWCA
Community Action Agencies
Nursing Homes
Rehabilitation Centers
Home Health Care Agencies
Family Planning Centers

The local Coordinating Councils would not be duplicative of existing structures within local communities but instead would create an environment in which rural providers would be afforded opportunities and incentives to work together. Conceptually the Local Coordinating Councils would be the hub of a wheel of providers' services. Clients would continue to access services the same as today but the hub would allow them, when necessary, to more readily

Cooperative Rural Networks and Affiliations



The expansion of health services in rural hospitals and family health centers has been stimulated by a number of budget allocations advanced by the Commission on Rural Resources. Projects are emphasized that coordinate and diversify health care services, address special rural needs, and/or hold the potential of delivering a broadened spectrum of care that's accessible to all members of the community.

access the range of services available to a rural area.

The Local Coordinating Council would have several functions. It would facilitate health and human service management for the community as a whole, assisting each provider to better coordinate services; act as conduit for needs assessment information so that appropriate action can be taken; gather and disseminate current information among providers; establish a mechanism to provide case management for clients with difficult/multiple problems requiring multi-agency action; and act as an advocate for needed service changes within the community. The Local Council would afford rural providers the opportunity to share facilities, personnel, and other resources. In some circumstances duplication could be minimized making more efficient use of available services. In short, the Local Councils would be the beginning of the solution to the problem of coordination in local rural communities. This program would be voluntary. Each Council would be expected to evolve along such lines and serve such geographic areas as dictated by local needs. Technical assistance for the development of these Councils will be made available.

In summary, the statewide Council for Rural Health and Human Resources composed of consumers, providers, private and public health professionals, and professional associations, would create for the first time at the state level an informed and enlightened voice and ear for the rural provider and populace in general. The local coordinating councils will provide a new means for rural health care providers and consumers to have coordinated input into the overall health and human services delivery system and to aid in maximizing resources at the local level.

Comments Received from Participants after Distribution of Workgroup Report:

- Include Rural Preservation Companies as part of list to participate in Local Coordinating Councils.

- Omission: what about representation of county governments on Local Coordinating Councils? [This question and it was felt that county government would end up controlling the council and thus, the council would be subject to politics.]

- What of SACs? Role of HSAs? Should we use existing structure? How can we avoid duplication of roles?

- Should not exclude any group or function - transportation, education should not be intentionally excluded.

- Geography question-local decision whether to have a Local Coordinating Council or not; local community, service providers would determine area Council would serve.

- Paid staff would be included as part of Council; grant funding, state agencies' reimbursement, are possible sources of monies for this purpose.

Public Comment:

The need for coordination of services was addressed extensively throughout the hearings. Speakers felt that greater coordination is needed at both the local and state levels. They suggested that a mechanism be developed that would review the regulations of different state agencies for conflict and unnecessary duplication, as well as conflict existing between state regulations and federal regulations.

Appendices

A. Public Policy and Programs for Rural Health Delivery

B. Classification of New York State Counties: Metro-Rural Continuum

C. Symposium Participants

D. Agencies, Associations and Councils that Directly Affect Rural Health Policy and Delivery Systems in New York State

Appendix A

Public Policy and Programs for Rural Health Delivery

Commission on Rural Resources' Rural Health Activities

Over the past few years, actions to improve rural health care delivery have been renewed at both the state and national levels. While much more remains to be accomplished, a strong foundation is gradually being constructed in New York State, upon which new programs and policy objectives can be built. The Legislative Commission on Rural Resources is proud to participate in this process, and gratified by the results of our efforts. Rural health care is being increasingly addressed not only by the Commission, but by the state Department of Health, the State Legislature, and various health care associations and agencies. (See Appendix D for a complete list.) The level of cooperation among these parties is encouraging, and is encouraged. To obtain maximum positive results from limited resources, such efforts require cooperation and continuous evaluation of accomplishments.

Following is a brief outline of activities and publications that have resulted thus far from initiatives of the Commission in cooperation with others. An overview of activities of other agencies and organizations is included as well.

Newly Enacted Laws Affecting Rural Health:

The laws described briefly in the following section are those which were initiated and have been continuously supported by the Commission. Each program was developed as a direct result of recommendations made to the Commission at several of its legislative symposia, meetings, and public hearings. Participants at such events represented the realm of individuals and organizations with an interest in rural health care, but the vast majority of these people were providers and consumers from rural areas of the state.

Rural Health Care Networking Program

Enacted in 1986, this law offers an aid program with grants of a maximum of $50,000 per year for up to three years to projects in rural health care networking. The program provides for technical assistance and financial support for the linking and organizational restructuring of separate providers in order to offer more integrated, comprehensive services than could be provided by any one provider independently. The first cycle of grants was awarded in October 1987, and the second round in November 1988.

Rural Health Care Provider Diversification Program

While originally an initiative of the State Senate, the Diversification Program is strongly supported by the Commission, which has worked extensively to insure adequate funding for the program. Projects supported by grants are those initiated by providers in order to diversify, expand, or enhance the services they offer, with a heavy emphasis on expanding the availability of both primary care and long term care in rural communities. Funding for this program has been maintained at $1 million per year since its inception in 1987.

Rural Health Care Development Program

Similar to the Diversification Program, the Rural Health Care Development Program was established to assist providers in diversifying the services they offer by expanding or enhancing existing services or establishing new services, in the areas of primary care and long term care, as well as geriatric care and emergency medical services. However, the Development Program is unique in that it was intended for projects which do not involve the conversion or merger of acute care facilities in rural communities. Funding for this program was $1 million for 1988-89; it is expected that this level of financial support will be maintained for the period 1989-90.

Rural Hospital Swing-Bed Demonstration Program

Established in 1988, the Swing-Bed Demonstration Program was developed to provide grants to rural acute care hospitals to cover planning and implementation costs for demonstration projects which would allow eligible hospitals some flexibility in the use of their certified beds. Such hospitals would be permitted to temporarily "swing" a small number of beds in order to use them for such alternative uses as skilled nursing care, hospice, geriatric day care, and respite care. The fiscal circumstances in the state in 1988 necessitated a delay in the implementation of this program; however, it is anticipated that a demonstration program will be operating in 1989.

Physician Recruitment, Retention and Clinical Training in Rural Areas

An appropriation of $318,000 was obtained in 1988 to fund enhancement of a model program for the recruitment, retention and clinical training of health care personnel and physicians in rural areas, conducted through the Family Practice Department of the State University of New York at Buffalo Medical School. The program is being conducted in cooperation with the Western New York Rural Health Care Cooperative, an organization recently established under a grant from the Robert Wood Johnson Foundation. Under the program, physician interns and residents are trained in rural hospitals. In addition, an Office of Rural Health will be established at the University, to serve as a clearinghouse of information on rural health care. Long-range plans for this program include replicating the model in other medical schools in the state.

University-Based Rural Health Research and Training Program

This 1988-89 State Budget appropriation of $200,000 is being used to establish demonstration rural health research and training programs within graduate programs in health services administration. The concept is to prepare prospective health care administrators to work in a rural setting, establish clinical residency programs in health services administration, stimulate research on rural health policy and practices, and serve as a clearinghouse for rural health and human services practitioners and policymakers. While many exciting and timely research projects are being undertaken, one of special significance is a study of the importance of a rural hospital on the economic climate of its community, as well as the economic impact on a rural community of its hospital. Results of the first round of research projects will be available in the fall of 1989.

State Office of Rural Affairs

In 1986, legislation developed and sponsored by the Commission was passed to establish an Office of Rural Affairs within the Executive Branch of state government. Among other duties, the Office provides comprehensive information and serves as a clearinghouse on federal, state and local rural development and revitalization programs, and refers agencies, individuals and corporations to appropriate departments and agencies of the state and federal governments.

Rural Public Transportation Coordination Program

Rural public transportation has been identified as a critical need in order to link providers and consumers of services. In 1986, legislation developed and sponsored by the Commission was enacted into law to

assist rural counties in developing a system for coordinating and integrating existing, often fragmented public transportation services. Such services are now often provided by many agencies to their specific client groups. A coordinated system would expand the use of facilities and resources to all potential clients, and increase service cost-effectiveness. Nine countywide projects are now underway, under the administration and guidance of the state Department of Transportation, to demonstrate the efficacy of this approach to public transportation service delivery in rural areas.

Commission Legislation Affecting Rural Health (Currently Pending):

Rural Representation on the Council on Home Care Services
The Commission has introduced legislation requiring the appointment of representatives of rural counties (those with a population of less than 200,000) to the state Council on Home Care Services, which advises the Governor and concerned state agencies on all aspects of home care services.

Rural Representation on the State Hospital Review and Planning Council
This bill, another Commission initiative, would increase rural representation on the State Hospital Review and Planning Council, which advises the Commissioner of Health on all health care issues, including health planning and regulation.

Rural Representation on the Public Health Council
Like the two bills above, this legislation would mandate an adequate level of rural representation on the Public Health Council, which develops health care policy and regulations in matters of public health.

Commission Publications Covering Rural Health Care:

Publications in the area of rural health care, distributed by the Commission, include the following:

Enabling Rural Hospitals in New York State to Provide Swing-Bed Care, March 1988.

Access to Capital: More Than Survival for Rural Hospitals and Nursing Homes, September 1987.

Regulating Rural Primary Ambulatory Care Services Centers: A Case Study Illustrating the Need for Regulatory Review, September 1987.

Rural Health Resource Guide: A Compilation of Data and Information on Rural Health in New York State, August 1987.

The Design of a Rural Health Services System for the Next Two Decades: Preliminary Report of the Second Legislative Symposium, August 1987.

Toward a Rural Health Policy in New York State: A Special Focus Report, April 1986.

Rural Futures, the Commission's monthly newsletter, frequently includes articles on rural health care.

Rural Health Activities of Other Agencies and Organizations

In addition to the work of the Commission, there are many other rural initiatives currently being implemented in New York. Agencies and organizations representing the spectrum of health care services and needs, each with its own thrust, are focusing specifically on health care delivery in rural areas. Major activities that have been brought to the attention of the Commission members and staff are featured in the following section.

Euphemia (Mickey) Hall, chairperson of the Task Force on Rural Health Strategies (of the NYS Hospital Review and Planning Council) as well as chair of the Rural Health Council (established in 1988 by the Governor), addressing symposium participants.

Program Initiatives and Activities:

The number of rural health care programs and activities currently underway prohibits a complete listing in the space available here. Following is a description of major initiatives and participants.

Task Force on Rural Health Strategies
In 1987 the NYS Hospital Review and Planning Council formed a Task Force on Rural Health Strategies, of which Commission Director Ron Brach served as a member. Chaired by Euphemia (Mickey) V. Hall, its purpose was to examine rural health issues and identify strategies to address priority concerns. A key recommendation of its report (*Toward Improving Rural Health Care*. November, 1987) was the establishment of a rural health council to monitor and evaluate statewide health policies and to promote rural network development (both of which were also recommended at the Commission's statewide rural health symposia).

Rural Health Council
In the Spring of 1988 the state Department of Health established a Rural Health Council (also chaired by Ms. Hall), to analyze and make recommendations regarding the delivery of health care services in rural areas. This Council reports to the Planning Committee of the larger State Hospital Review and Planning Council, which is responsible for health care planning and regulation throughout the state. Major efforts of the Rural Health Council at this point include: developing a Voluntary Self-Assessment Tool for rural hospitals; analyzing reimbursement methods for community-based care; and exploring the development of a statewide 911 emergency response system.

State Health Planning Study
The Council on Health Care Financing is currently completing a study of the health care planning system in New York State, analyzing planning methods and alternatives at both the state and local levels. The Council is developing a proposal regarding the future of the health planning system, which it will submit to the Legislature during the 1989 session.

The Director of the Office of Rural Affairs, Joseph Gerace, addressing the symposium participants.

Trade Associations — Rural Task Forces

Many statewide health care trade associations have recently recognized the importance and unique nature of service delivery in rural areas. Thus, they have established task forces or committees to specifically address rural concerns, and report to the full membership. The Rural Health Task Force of the New York Association of Homes and Services for the Aging (NYAHSA), for example, recently completed a report devoted strictly to rural issues. Some associations which now have rural task forces include: the Hospital Association of New York State (HANYS); the state Farm Bureau; the New York Association of Homes and Services for the Aging (NYAHSA); and the Home Care Association of New York.

Rural Health Conference

The State Office of Rural Affairs is planning its first major activity in the area of rural health care by sponsoring a Rural Health Conference in December 1988. The Conference is to be co-sponsored by the Department of Health.

Appendix B

*Classification of NYS Counties**

Metropolitan - Rural Continuum

Graphic presentations throughout this report were produced using a set of six categories of **county types**. Counties are grouped along a continuum from the most metropolitan (Type 1) to the most rural (Type 6).

Type 1: Downstate Metropolitan
Type 2: Upstate Metropolitan
Type 3: Rural With Extensive Urban Influence
Type 4: Rural With Considerable Urban Influence
Type 5: Rural With Moderate Urban Influence
Type 6: Rural With Limited Urban Influence

The 62 NYS counties in the six county types, from **Most Metropolitan** to **Most Rural** are:

Metropolitan----------Rural

Type 1	Type 2	Type 3	Type 4	Type 5	Type 6
Bronx					
Kings					
Nassau	Albany				
New York	Broome				
Queens	Dutchess	Cayuga			
Richmond	Erie	Fulton			
Rockland	Monroe	Genesee	Cattaraugus		
Suffolk	Niagara	Madison	Chautauqua		
Westchester	Oneida	Montgomery	Chemung	Columbia	
	Onondaga	Ontario	Clinton	Greene	
	Orange	Oswego	Cortland	Hamilton	Allegany
		Rensselaer	Jefferson	Schoharie	Chenango
		Saratoga	Otsego	Schuyler	Delaware
		Schenectady	St. Lawrence	Seneca	Essex
		Wayne	Steuben	Tioga	Franklin
			Tompkins	Washington	Lewis
			Ulster	Wyoming	Sullivan
			Warren	Yates	

*For details on the design of this classification system, see the Commission's report, ***Socioeconomic Trends in Rural New York State: Toward the 21st Century*** (1984).

Special Note to Readers:
In recommending rural health policy and programs the Commission recognizes there are outlying areas within several metropolitan counties that have rural needs and conditions. Therefore, such rural areas are typically included in program eligibility criteria developed by policymakers, along with the 44 rural counties. In all, approximately 80 percent of the state's land area is rural in character and home to over 3 million New Yorkers.

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Appendix D

Agencies, Associations, and Councils that Directly Affect Rural Health Policy and Delivery Systems In New York State

A great many state and federal agencies and health care trade associations undertake activities which have a direct bearing on health care facilities and providers in rural New York. An often repeated complaint of rural providers is the number of agencies with which one has to work in order to receive approval for a project, to solve problems or complications or to obtain information. The great number of state executive and legislative agencies, each having particular regulations and requirements, means much of the already limited professional staff time in rural facilities is devoted to learning about and complying with regulations.

This appendix contains a listing of some of the many agencies and organizations involved in health care policy and service delivery. This includes state executive offices, departments, and advisory councils; state legislative committees, task forces, and commissions; federal government agencies; and various health care associations, agencies and interest groups.

Executive Branch

Office of the Governor

Department of Health

Office of Rural Affairs

Department of Social Services

Department of Mental Hygiene

- Office of Mental Health
- Office of Mental Retardation and Developmental Disabilities
- Office of Alcoholism and Substance Abuse
  - Division of Alcoholism and Alcohol Abuse
  - Division of Substance Abuse Services

Office of the Advocate for the Disabled

Office for the Aging

Department of Labor

Division of the Budget

Insurance Department

Medical Care Facilities Finance Agency (MCFFA)

State University of New York

Department of Transportation

Research Foundation for Mental Hygiene

Department of Public Service

Department of State

Division of Housing and Community Renewal

Federal Government Agencies

Department of Health and Human Services
- Public Health Service
- Health Care Financing Administration
- Social Security Administration
- Office of Human Development Services
- Human Nutrition Information Service

Economic Development Administration

Department of Housing and Urban Development

Occupational Safety and Health Administration

Department of Transportation

Health Care Associations, Agencies, Authorities and Interest Groups

Family Planning Advocates of New York State, Inc.

Home Care Association of New York State, Inc.

Medical Society of New York State

New York Association of Private Hospitals, Inc.

New York State Health Facilities Association

New York Association of Adult Homes, Inc.

Health Insurance Association of America

New York State Society of Physician's Assistants

New York State Public Health Association

Hospital Trustees of New York State

Hospital Association of New York State
- Central New York Hospital Association
- Greater New York Hospital Association
- Northeastern New York Hospital Ass'n
- Nassau-Suffolk Hospital Council
- Northern Metropolitan Hospital Ass'n
- Rochester Region Hospital Association
- Western New York Hospital Association

New York State Association of Counties

The Association of Towns of New York State

NYS Conference of Mayors and Other Municipal Officials

New York State School Boards Association

New York State Rural Schools Program

NYS Ass'n of Independent Colleges and Universities

NY Ass'n of Homes and Services for the Aging

New York State Academy of Family Physicians

New York Public Welfare Association

NYS Area Offices for the Aging

Statewide Senior Action Council

The Business Council of New York State

NYS Health Maintenance Organization Conference

NYS Association of Health Systems Agencies
- HSA of Northeastern New York
- Hudson Valley HSA
- Finger Lakes HSA
- HSA of Western New York
- Central New York HSA
- HSA of New York City
- Nassau-Suffolk HSA
- NY-PENN HSA

NYS Facilities Development Corporation

Council of State Governments

National Conference of State Legislatures

Legislative Branch

Senate Standing Committees:

Aging
Alcoholism and Drug Abuse
Health
Mental Hygiene
Social Services
Insurance
Child Care
Finance
Transportation
Education
Environmental Conservation
Higher Education
Labor
Housing and Community Development

Assembly Standing Committees:

Aging
Alcoholism and Drug Abuse
Health
Mental Health
Social Services
Insurance
Children and Families
Education
Higher Education
Transportation
Ways and Means
Environmental Conservation

Senate Select and Special Committees:

Select Committee on the Disabled

Assembly Task Forces:

Task Force on the Disabled
Task Force on Food, Farm and Nutrition Policy
Task Force on the Homeless

Joint Senate-Assembly Commissions:

Council on Health Care Financing
Commission on Rural Resources
Administrative Regulations Review Commission
Commission on Toxic Substances and Hazardous Wastes

Executive Branch Councils and Committees

Office of the Governor:

Council on Children and Families

Council on Developmental Disabilities Planning

State Board of Social Welfare

Commission on Child Care

Task Force on Adolescent Pregnancy

Elderly Pharmaceutical Insurance Coverage Panel

Commission on Quality of Care for the Mentally Disabled

Worker's Compensation Board

State Boards for the Professions (dentistry, medicine, nursing, chiropractic, occupational therapy, ophthalmic dispensing, optometry, pharmacy, physical therapy, podiatry, psychology, social work, speech-language pathology and audiology)

Department of Health:

Public Health Council

Hospital Review and Planning Council

Rural Health Council

Advisory Council on Physician's Assistants and Specialist's Assistants

Board of Examiners of Nursing Home Administrators

Emergency Medical Services Council

Council on Home Care Services

Statewide Health Coordinating Council

NYS Health Services Corps

State Board for Professional Medical Conduct

Department of Mental Hygiene:

Mental Health Services Council

Advisory Council on Mental Retardation and Developmental Disabilities

Council on Community Residential Services to the Mentally Retarded and Developmentally Disabled

Council on Intermediate Care Facilities for the Mentally Retarded

Advisory Council on Alcoholism Services

Advisory Council on Substance Abuse

Council for Mental Hygiene Planning

Department of Social Services:

Medical Advisory Committee

Rural Services Advisory Committee

Department of Transportation:

Interagency Coordinating Committee on Rural Public Transportation